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Supreme Court, U.S.
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In The

Supreme Court of the United States

RICHARD B. HELFRICH, M.D.,
and DANIEL B. NELSON, M.D.,

Petitioners,

v.

CARLE CLINIC ASSOCIATION, P.C.,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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FIRST QUESTION PRESENTED

Whether and under what circumstances the doctrine of estoppel should be applied to benefit plans governed by the Employee Retirement Income Security Act ("ERISA"), where conflict exists among the Circuits as to the application of estoppel to ERISA claims.

SECOND QUESTION PRESENTED

Whether a presumption should be granted to a prevailing party requesting an award of attorneys' fees and costs under Section 1132 of ERISA, where the majority of Circuits do not extend that presumption.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

The Petitioners in this case are individuals, Richard B. Helfrich, M.D., and Daniel B. Nelson, M.D.

The Respondent is Carle Clinic Association, P.C. According to disclosures Respondent made with the Seventh Circuit Court of Appeals, there is no parent or publicly held company owning 10% or more of the stock of Respondent.

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PETITION FOR A WRIT OF CERTIORARI

Richard B. Helfrich, M.D., and Daniel B. Nelson, M.D., respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The decision of the Court of Appeals denying rehearing (App. 59) is reported at 2003 U.S.App. LEXIS 13513. The decision of the Court of Appeals on the merits (App. 1) is reported at 328 F.3d 915 (7th Cir. 2003). The decision of the District Court granting summary judgment for Respondent (App. 26), granting Respondent's petition for attorneys' fees (App. 50), the report and recommendation of the magistrate judge (App. 9), and the order adopting the report and recommendation (App. 19) are unreported.

STATEMENT OF JURISDICTION

The judgment of the Court of Appeals was entered on May 12, 2003 (App. 1), and a petition for rehearing was denied on July 1, 2003 (App. 5). The jurisdiction of this Court to review the judgment of the Court of Appeals is invoked under 28 U.S.C. §1254(1).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

No constitutional provisions are involved in this case. The primary statute involved in this case is 29 U.S.C.

§1132. The text of this statute is set forth in the appendix (App. 60).

STATEMENT OF THE CASE

Petitioner Richard B. Helfrich, M.D., ("Helfrich"), was employed by Respondent Carle Clinic Association of Illinois ("Respondent") from August, 1969 until his retirement in February, 1997. Petitioner Daniel B. Nelson, M.D., ("Nelson"), was employed by Respondent from July, 1977 until he took disability leave on June 17, 2001.

In 1946, Respondent started a pension plan for its employees, which it amended on several occasions. During the 1970's and 1980's, Respondent created and distributed three written summaries of its pension plan. These summaries promised Respondent's physician-employees that its basic pension plan provided "50% of average income of the highest consecutive five of the last fifteen years for retirement" and "fully vested at ten years."

These summaries were distributed to employees, including Petitioners, when published; however, complete versions of the Plan were not distributed until the 1990's. Because of the pension benefits offered by Respondent in these summaries, Petitioners chose not to pursue other career opportunities during the years they worked for Respondent. Nelson resigned from other employment to accept a job offer with Respondent, and passed over more lucrative employment in other communities, largely because of the pension plan offered in the summaries. Petitioners relied upon the representations of the summaries when making employment decisions, career plans, financial obligations and in continuing employment with

Respondent. In exchange for the compensation they were promised, Petitioners provided decades of service to Respondent and the patients they treated. Despite the promises contained in the Respondent's written summaries of its pension plan, the Respondent's pension plan documents contained benefit limitations. No limitation language appeared in a Summary Plan Description until 1996, when Respondent issued a document entitled "Summary Plan Description for Carle Clinic Association Pension Plan." The 1996 Summary Plan Description stated that pension benefits would be subject to IRS limitations. These limitations referred to in the Plan were later identified by Respondent as 26 U.S.C. §415 of the Internal Revenue Code ("IRC"), which purports to limit (or cap) benefits and contributions in qualified plans ("IRC caps").

Petitioners, who had not received the full plan document but only the written summaries of plan documents, did not know that IRC caps existed in the Plan until at least 1994, when the possibility arose that Respondent might not keep the promises contained in these summaries.

A group of twenty Carle physician-employees ("Physicians") and their legal counsel engaged in a written colloquy with the Board to resolve the pension-funding issue. During this time period, internal documents were created which acknowledged that Respondent had promised its employees a certain level of benefits and questioned *whether or not* Respondent should fulfill those promises or pay out reduced benefits pursuant to 26 U.S.C. §415.

For example, on February 8, 1995, Respondent's CEO wrote a letter stating, "The Board has already acted upon the question of *whether to abide* by the legal pay out limits (415 limits) which have been in place since 1976. The Board *has decided* not to make adjustments to individuals impacted by this law." (emphasis added) The document contained an outline with headings such as "Recognize or Ignore Payout Limits? (415 Limits)." The document stated that the limits had "[l]ittle impact in the past – our actuaries didn't even discuss 415 limits before 1989" and that ignoring payout limits would be positive to Respondent because it would eliminate the " 'not informed' argument", but would be "[e]xtremely expensive."

On December 18, 1995, Respondent approved a lump-sum benefit of $2 million to be shared among the Physicians in exchange for a written waiver of the full retirement benefits promised them in Respondent's pension plan summaries. Sixteen of the Physicians signed waivers in exchange for a proportionate share of the benefit. Petitioners refused to sign a waiver but continued negotiations.

After four years of direct discussion, Respondent's CEO notified Helfrich's counsel that the matter would be submitted to its in-house "Plan Administrators." Both Helfrich and Nelson's benefits claims were denied by Respondent's Administrators, though both Administrators later filed affidavits in this cause admitting they had never reviewed Petitioners' claims.

On September 30, 1999, Petitioners filed a Complaint with the United States District Court for the Central District of Illinois, Danville/Urbana Division, seeking those benefits promised in Respondent's written summaries.

Subject matter jurisdiction of the District Court arose from the federal question created by Counts I and III of the Complaint brought pursuant to the Employee Retirement Security Act (hereinafter "ERISA"), Title 29 U.S.C. §1132(a). The Complaint prayed the District Court to make declarations of the rights as to interested parties. Jurisdiction for the declaration of rights as to interested parties arose under Title 28 U.S.C. §2201(a). Counts II and IV of the Complaint alleged breach of contract actions under state law. Supplemental jurisdiction for these pendant state claims arose under Title 28 U.S.C. §1367(a). Venue was proper pursuant to 28 U.S.C. §1391(b)(c).

On December 3, 1999, Respondent filed a Motion to Dismiss Petitioners' Complaint. On April 3, 2000, Magistrate Judge David Bernthal issued a Recommendation that Respondent's Motion to Dismiss be denied, stating:

> This case does not involve claims processing nor are Plaintiffs requesting a review of the amount of their benefit under the requested Plan. Plaintiffs do not assert that their benefits have been calculated incorrectly under the restated Plan or that they are entitled to greater benefits under the restated Plan. There appear to be no factual disputes as to what the restated Plan requires or provides, or to the correctness of the plan administrator's interpretation of the Plan. *Instead, the issues in this suit are related to the question of whether Plaintiffs are entitled to the amount they would have received under the original Plan and whether Defendant had a right to unilaterally, and without compensation, change the terms of their employment contract.* (App. 14) (Emphasis added)

Thereafter, the District Court dismissed Petitioners' state law claims, finding they were pre-empted under

ERISA, denied Respondent's Motion to Dismiss Petitioners' ERISA claims, and adopted the Recommendation of the Magistrate as to Petitioners' ERISA counts. (App. 24-25)

In September, 2001, Petitioners and Respondent each filed Motions for Summary Judgment. On June 4, 2002, the District Court denied Petitioners' Motion for Summary Judgment, basing its ruling in part on the understanding that the Seventh Circuit had not extended the doctrine of estoppel to ERISA cases involving an unfunded pension plan. The District Court granted Respondent's Motion for Summary Judgment. (App. 48)

Respondent subsequently filed a Petition for Attorneys' Fees and Expenses, requesting $160,776.36. After briefing, on October 3, 2002, the District Court granted Respondent's Petition in its entirety, ordering Petitioners to pay $160,776.36. (App. 57) Petitioners appealed both the June 4, 2002 summary judgment ruling and the October 3, 2003 attorneys' fees ruling to the Seventh Circuit Court of Appeals. Jurisdiction was conferred upon the Seventh Circuit Court of Appeals pursuant to 28 U.S.C. §1291.

On May 12, 2003, the Seventh Circuit Court of Appeals decided the case at bar. Though the Court explicitly found that Respondent had promised its employees the benefits Petitioners sought, the Court dismissed Petitioners' estoppel claim. The Court stated that the Seventh Circuit has not fully embraced the doctrine of estoppel in ERISA cases; it then declined to review Petitioners' estoppel claim, holding that granting relief would deny the Respondent a tax benefit and threaten the financial viability of the Plan.

The Court of Appeals did not apply an established test widely used among the Circuits (and previously used by

the Seventh Circuit) for determining the appropriateness of an award for attorneys' fees and costs, and instead ruled that because Respondent faced a substantial financial liability its attorneys' fees were reasonable and should be granted.

On May 27, 2003, Petitioners filed a Petition for Rehearing and Rehearing En Banc.

In their Petition, Petitioners stated that the Court of Appeals' ruling made erroneous assumptions, arguing:

1) Respondent's actuarial soundness and tax-exempt status of Respondent's Plan would not have been compromised if the Court granted relief to the Petitioners. In 1996, Respondent paid or made available $2 million dollars, outside its Plan framework, for retirement purposes to those employees affected by the IRC caps, *notwithstanding the existence of those caps*. Despite Respondent's recurrent argument that its actions against Petitioners were motivated by preserving the Plan's tax-exempt status, Respondent was still able to provide these funds, without triggering adverse tax consequences or compromising the Plan's actuarial soundness.

2) Respondent would not need to contribute $20 million to pay Petitioners their benefits promised in excess of IRC caps. Indeed, all but four of the affected physicians (including Petitioners) had signed irrevocable waivers of the benefits now claimed by the Petitioners, each of whom received their respective shares of the $2 million payout in 1996. A ruling by the District Court in favor of Petitioners would not have affected Respondent

beyond the amount of judgment in favor of Petitioners and the potential claims of the two other physicians who did not waive the benefits promised by Respondent's written pension plan summaries. Assuming that Respondent paid the judgment out of its general revenue, as it paid the other sixteen physicians in 1996, the Plan would not be affected at all.

3) Petitioners clearly argued for a non-tax qualified plan from which to pay the promised benefits. Petitioners raised this issue in their state law claims (Counts II & IV of their Complaint), and in their motion for Summary Judgment. Specifically, Petitioners argued both in its Motion for Summary Judgment and on appeal that Respondent should be ordered to make payment to Petitioners through an excess benefit plan, in the same fashion as with the Respondent's previous $2 million payout to 16 other physician-employees. This payout, more than anything else, demonstrated it was feasible to grant Petitioners relief without raising any ERISA policy concerns.

The Petition for Rehearing was denied on July 1, 2003. (App. 59)

REASONS FOR GRANTING WRIT

I. The Court should apply the doctrine of estoppel to benefit plans governed by ERISA where it is consistent with legislative policy and common law.

A. There is recurring conflict among the circuits on the application of estoppel to ERISA claims.

Congress passed ERISA, 29 U.S.C. §§1001 *et seq.*, with the expectation that the courts would develop a federal substantive law to deal with those issues unresolved by the text of ERISA. *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 156, 105 S.Ct. 3085, 3097, 87 L.Ed.2d 96, 111 (1985). Federal courts have periodically approved of the use of the doctrine of promissory estoppel as a means to "plug in the gaps" found in ERISA, albeit in a haphazard manner.

A plurality of the Circuits agree that estoppel principals apply in at least some ERISA cases, although they do not agree as to whether the doctrine is applicable to both welfare and benefit plans, nor do they agree on a single test to determine when to apply the doctrine. *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 85 (2nd Cir. 2001); *Burstein v. Retirement Account Plan for Employees of Allegheny Health Educ. & Research Found.*, 334 F.3d 365, 383 (3rd Cir. 2003); *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 403 (6th Cir. 1998); *Coker v. Trans World Airlines, Inc.*, 165 F.3d 579, 585 (7th Cir. 1999); *Alaska Trowel Trades Pension Fund v. Lopshire*, 103 F.3d 881, 883 (9th Cir. 1996); *Katz v. Comprehensive Plan of Group Ins.*, 197 F.3d 1084, 1090 (11th Cir. 1990). A minority of circuits have refused outright to apply the doctrine of estoppel to ERISA cases, *Bakery & Confectionery Union & Indus. Int'l*

Pension Fund v. Ralph's Grocery Co., 118 F.3d 1018, 1027 (4th Cir. 1997); *Bourgeois v. Pension Plan for the Employees of the Santa Fe Int'l Corps.*, 215 F.3d 475, 481-482 (5th Cir. 2000); *Miller v. Coastal Corp.*, 978 F.2d 622, 624-625 (10th Cir. 1992) and two Circuits have acknowledged that it is an open question whether estoppel applies to ERISA cases. *Mauser v. Raytheon Co. Pension Plan for Salaried Employees*, 239 F.3d 51, 57 (1st Cir. 2001); *Jensen v. Sipco, Inc.*, 38 F.3d 945, 953 (8th Cir. 1994).

This uneven application of estoppel principles to ERISA cases imposes economic costs to multi-circuit actors, in that it denies ERISA benefits to claimants in some circuits that are available to actors in other circuits. This Court's intervention is required to harmonize its application.

B. This Court should exercise its supervisory role to reverse an erroneous decision by the Seventh Circuit on whether to apply estoppel principles in this case.

As cited above, the Seventh Circuit has applied the doctrine of estoppel to some ERISA cases. It stated in *Miller v. Taylor Insulation Co.*, 39 F.3d 755 (7th Cir. 1994) that it viewed promissory estoppel as a part of the common law it had been instructed by the Supreme Court to create in order to "plug gaps in ERISA." *Miller*, 39 F.3d at 759 citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110, 109 S.Ct. 948, 954, 103 L.Ed.2d 80, 92 (1989).

Prior to its ruling in this case, the test required by the Seventh Circuit for a cause of action for ERISA estoppel consisted of 1) a knowing misrepresentation, 2) made in

writing, 3) with reasonable reliance on that misrepresentation by the plaintiff, 4) to the plaintiff's detriment. *Coker v. Trans World Airlines, Inc.*, 165 F.3d 579, 585 (7th Cir. 1999).

However, the Seventh Circuit has failed to extend the estoppel doctrine to unfunded single-employer retirement plans, despite application of estoppel in other situations. In *Black v. TIC Inv. Corp.*, 900 F.2d 112, 115 (7th Cir. 1990), the Seventh Circuit held that in the case of an unfunded, single-employer ERISA welfare plan, "there is no particular fund which is depleted by paying benefits. Thus there is no need for concern about the Plan's actuarial soundness." The fact that the ERISA plan examined by the *Black* Court was *a single-employer, unfunded* Plan was determinative. More important, the *Black* court found:

> In cases such as these where there is no danger that others associated with the Plan can be hurt, there is no good reason to breach the general rule that misrepresentations can give rise to an estoppel. There is no reason for the employee who reasonably relied to his detriment on his employer's false representations to suffer. There is no reason for the employer who misled its employee to be allowed to profit from the misrepresentation.

Black, 900 F.2d at 115.

Despite the Seventh Circuit's failure to recognize the doctrine of estoppel to unfunded single-employer retirement plans, several District Courts within the Seventh Circuit have found estoppel to be applicable under similar circumstances. For example, in *Kuehl v. Chrysler Pension Plan*, 895 F.Supp. 1147 (E.D.Wis. 1995), the doctrine was applied to single-employer retirement funds under the

rationale that the actuarial soundness of the Plan affecting employees from other companies would not be threatened. In *Kuehl v. Chrysler Pension Plan*, 895 F.Supp. 1147, 1157 (E.D.Wis. 1995), the District Court denied the defendant employer's motion for summary judgment as to the issue of promissory estoppel for the single-employer retirement plan of the Chrysler Corporation stating, "Where better to apply estoppel than in the present situation, where ERISA prevents recovery to an employee who certainly appears to have been misled?" *Kuehl*, 895 F.Supp. at 1157. See also *Stanek v. AT&T, et al.*, No. 96-C-4096, 1997 U.S.Dist. LEXIS 3716 (N.D.Ill. March 28, 1997) (finding a cause of action for an estoppel claim against a single-employer pension fund); *Lockrey v. Leavitt Tube Employees Profit Sharing Plan*, 766 F.Supp. 1510 (N.D.Ill. 1991) (granting employee's motion for summary judgment in a single-employer retirement fund).

In the case at bar, Respondent made knowing, written misrepresentations to both Petitioners when it issued detailed pension plan summaries, and then, before any employees retired under the promises of Respondent's pension plan summaries, it greatly reduced these benefits, a classic "bait-and-switch."

This misrepresentation was compounded by Respondent's failure to inform the Petitioners that it would rely on IRC caps to avoid paying retirement benefits previously promised to them when funding requirements became more expensive than Respondent desired to pay. Respondent's intentions were hidden even from Helfrich, a former Board Chairman and pension committeeman who spent years attempting to fund those benefits promised under Respondent's pension plan summaries. For example, as late as October, 1994, Respondent distributed a timeline of

its retirement programs that prominently mentioned the 50% of average income promise of Respondent's pension plan summaries, but did not mention that those benefits would not be paid in full. Respondent again acknowledged its "'promise to pay' **50% of average income** that was given to employees prior to 10/01/89" in a February 1995 memorandum. (Emphasis contained in original document)

Moreover, it was reasonable for Petitioners to rely on Respondent's misrepresentations for two independent reasons: (1) these representations came directly from Respondent in its pension plan summaries and other documents described above, with no words of limitation, and (2) Respondent, as detailed above, withheld its intentions regarding the payment of benefits from the Petitioners until long after the promises were made, so as to extract maximum benefits from these promises without delivering the *quid pro quo*. As Respondent's administrator C. Carleton King put it, this withholding of information was justified because "limits were not believed to be a factor until the late 1980's when participants were made aware that payout limits existed." King reasoned, "[t]he financial burden resulting from elimination of [payout] limits would have a significant effect on physician incomes which could jeopardize the Clinic's ability to recruit and retain physicians." Finally, the Petitioners suffered as a result of the misrepresentation through a combination of reduced benefits and lost employment opportunities passed over in reliance on Respondent's broken pension promises.

Documents generated by Respondent demonstrate that Respondent *chose* not to pay the full benefits promised to Petitioners. Respondent's CEO, in a February 8, 1995 letter stated: "The Board *has decided* not to make adjustments" (emphasis added). This letter contained

headings such as "Recognize or Ignore Payout Limits? (415 Limits)" and an outline which literally weighed the "pros" and "cons" of paying promised benefits. This document acknowledged Respondent's misrepresentations, stating that the limits had "[l]ittle impact in the past – our actuaries didn't even discuss 415 limits before 1989", that ignoring payout limits would be a "pro" to Respondent because it would eliminate the "'not informed' argument" and be a "con" to Respondent because it would be "[e]xtremely expensive."

Respondent operated single-employer pension plans, some of which were funded, while others were not. The benefits claimed by Petitioners were so-called "excess benefits" *from an unfunded plan*, a plan that was available to other Respondent physician-employees. The $2 million benefit paid in 1996 was an example of Respondent's contribution to this unfunded plan. These contributions were not dependent on their deductibility to Respondent and were available on a tax-deferred basis to the physician-employees who received them. Finally, Respondent's contributions were paid out of *Respondent's general assets and revenue*, not from the plan.

Despite the bevy of factual support and complimentary case law, Petitioners' estoppel claims were never reviewed on the merits. The District Court declined review on the basis that the Seventh Circuit had not yet applied the doctrine to a single-employer retirement fund. The Seventh Circuit also refused to analyze Petitioners' estoppel claim, citing the erroneous factual assumptions discussed in the Statement of the Case.

This court can and should fashion a rule that applies estoppel principals where: 1) there is an ambiguity in the

plan document itself or a conflict between the plan document and a summary plan description; 2) for a single-employer unfunded retirement or welfare benefit plan, and 3) where the other substantive requirements of estoppel, as harmonized by this Court, are found. Such a rule would bring order to an otherwise disjointed body of federal common law. It would protect plans with fiduciaries serving multiple client employers, while also protecting the actuarial integrity of any single-employer plan. It also would protect Petitioners, and countless other employees of single-employer plans from having their common law contractual claims subsumed by an ERISA statute that grants no substantive remedy.

II. This Court Should Confirm the Majority of Circuits' Prohibition Against the Presumption that a Prevailing Party is Entitled to Attorneys' Fees and Costs under §1132 of ERISA.

ERISA was enacted by Congress "to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." *Black & Decker Disability Plan v. Nord*, 123 S.Ct. 1965, 1970, 155 L.Ed.2d 1034, 1042 (2003). To that end, Section 1132(g)(1) of ERISA authorizes "[i]n any action under this title . . . by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorneys' fee and costs of action to either party." 29 U.S.C. §1132(g)(1).

A. The Seventh Circuit's Ruling in This Cause Creates a Presumption in Favor of a Prevailing ERISA Litigant That Conflicts With The Prior Decisions of This Court and The Majority of Circuit Courts.

The Seventh Circuit's ruling in this cause replaced what had been a "modest presumption" with a sweeping entitlement to attorneys' fees and costs in ERISA cases.

The First, Second, Third, Fourth, Fifth, Sixth, Eighth, Tenth, Eleventh, and D.C. Circuits have all rejected the presumption that a prevailing party is entitled to attorneys' fees in ERISA cases; only the Seventh and Ninth Circuits maintain it. *Martin v. Arkansas Blue Cross & Blue Shield*, 299 F.3d 966, 970 (8th Cir. 2002) (surveying and summarizing the positions of the respective circuits position on fee-shifting under ERISA). The presumption is not supported by the statute's language or legislative history of the provision. Indeed, §1132(g)(1) lacks any legislative history which might provide guidance to courts. *Armistead v. Vernitron*, 944 F.2d 1287, 1303 (6th Cir. 1991).

This Court has not decided whether there should be any presumption of fee-shifting in ERISA cases. However, in analyzing an attorneys' fees provision of the Copyright Act (17 U.S.C. §505), this Court held that where a statute provides that fees may be granted at the Court's discretion, further statutory language would be required to create a presumption in favor of attorneys' fees. *Fogerty v. Fantasy, Inc.*, 510 U.S. 517, 534, 114 S.Ct. 1023, 1033, 127 L.Ed.2d 455, 469 (1994). The Court in *Fogerty* found that a presumption in favor of the automatic awarding of attorneys' fees would be contradictory to the discretion given to the court by the statutory language. *Fogerty v. Fantasy,*

Inc., 510 U.S. 517, 534, 114 S.Ct. 1023, 1033, 127 L.Ed.2d 455, 469 (1994). The *Fogerty* Court also held that Courts may use nonexclusive factor tests in determining whether an award of attorneys' fees is appropriate. *Fogerty*, 510 U.S. at 535, 114 S.Ct. at 1033, 127 L.Ed.2d at 471.

In ERISA cases, the majority of Circuits have, indeed, applied a five-factor test in determining whether or not a party is entitled to attorneys' fees and expenses. These five factors include: 1) the degree of the offending parties' culpability or bad faith; 2) the ability of the offending parties to satisfy personally an award of attorneys' fees; 3) whether an award of attorneys' fees would deter other persons acting under similar circumstances; 4) the amount of benefit conferred on members of the pension plan as a whole; and 5) the relative merits of the parties' positions. *Nichol v. Pullman Standard, Inc.*, 889 F.2d 115, 121 (7th Cir. 1989). This test has been applied by the First, Second, Third, Fourth, Fifth, Sixth, Seventh, Ninth, Tenth, Eleventh, and the D.C. Circuits. *Eddy v. Colonial Life Insurance*, 59 F.3d 201 (D.C. Cir. 1995).

The Seventh Circuit position on fee-shifting in ERISA cases is a patchwork product. It alternatively accepts the five-factor test used by other circuits or it uses the fee-shifting standard employed under the Equal Access to Justice Act ("EAJA"). *Bittner v. Sadoff & Rudoy Indus.*, 728 F.2d 820, 830 (7th Cir. 1984). The Seventh Circuit does not use one test over another with any predictability, other than to occasionally note that the five-factor test is not well suited to prevailing ERISA defendants. *Id.* Other circuits have specifically rejected the EAJA fee-shifting approach in ERISA cases along with the presumption. *Gray v. New England Telephone and Telegraph Co.*, 792 F.2d 251, 258-259 (1st Cir. 1986).

Despite these seemingly different standards, recent Seventh Circuit decisions claim that both tests are really the same. One such decision held: "Although we have formulated the test for when attorneys' fees should be awarded under ERISA in various ways, we have recently noted that the various formulations boil down to the same bottom-line question: 'Was the losing party's position substantially justified and taken in good faith, or was that party simply out to harass its opponent?'" *Hess v. Hartford Life & Accident Ins. Co.*, 274 F.3d 456, 464 (7th Cir. 2001). The Seventh Circuit previously defined "substantially justified" as "the loser's position, while rejected by the court, has a solid basis – more than merely not frivolous, but less than meritorious." *Meredith v. Navistar Int'l Transp. Co.*, 935 F.2d 124, 128 (7th Cir. 1991), citing *Bittner v. Sadoff & Rudoy Indus.*, 728 F.2d 820, 830 (7th Cir. 1984).

In fact, the Seventh Circuit's instant ruling dispensed with the five-factor test, the EAJA test, and even with an analysis of whether the Petitioner's position was substantially justified or taken in good faith. An application of either of these tests would have shown that Respondent's claim for attorneys' fees should have been denied. Petitioners again refer this Court to the Seventh Circuit's finding that Respondent had promised the sought after benefits and to the Recommendation of the Magistrate adopted by the District Court as evidence that, although their cause of action was not ultimately successful, it possessed merit. Instead, the sum total of the Court's analysis on the fee-shifting issue in this case consists of the following paragraph:

> As for attorneys' fees: the district court did not abuse its discretion in concluding that [Respondent], the prevailing party, is entitled to recompense under 29 U.S.C. § 1132(g)(1), which says that "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." Nor did the district judge err in concluding that fees in the range of $160,000 are reasonable, given the stakes of the case: a loss would have cost Carle $20 million or more and had awful tax consequences for many current and former employees. Carle retained ERISA specialists to protect its interests; this was a prudent step. (Plaintiffs stress that they hired less expensive lawyers. The difference shows. You get what you pay for.)
>
> App. 7

Notwithstanding its factual inaccuracies (discussed in the Statement of the Case), this ruling represents a sweeping change in ERISA fee-shifting jurisprudence: It justifies an award of attorneys' fees solely because the prevailing party has, for lack of a better term, "a lot of money at stake", regardless of the merits of a claimant's case or his ability to pay the award.

This decision belies the Seventh Circuit's claim that the presumption in favor of granting attorneys' fees to successful ERISA litigants is a "modest" one. Gone is the examination of whether the losing party's position was substantially justified and taken in good faith. Now more than ever, the Seventh Circuit's fee-shifting analysis is squarely at odds with nine other Circuit courts and, by implication, the prior decisions of this Court.

B. A presumption granting attorneys' fees to prevailing parties has a chilling effect on the ability of employees to obtain competent counsel to prosecute all but the most obvious instances of employer/fiduciary misconduct.

In the case at bar, the Seventh Circuit not only championed the presumption that attorneys' fees will be granted, but also deviated from its prior analysis and the tests used in any other Circuit. The Court did not use either the five-factor test or the substantially justified, good faith test when it reviewed the trial court's decision to award Respondent its attorneys' fees. Instead, the Court abandoned its own precedent and the methodologies of all other Circuits, deciding that since the Respondent faced substantial financial liability, its attorneys' fees should be granted. The Court of Appeals found that Respondent's attorneys' fees were generally reasonable. This ruling is not only at odds with prior Seventh Circuit decisions and those of other Circuits, it sets a dangerous precedent dictating that any unsuccessful ERISA plaintiff stands to pay defendant's attorneys' fees – regardless of the amount or whether plaintiff can pay it – whenever a defendant faces a high or undetermined amount of liability.

This Court held in *Christiansburg Garment Co. v. Equal Employment Opportunity Comm'n*, 434 U.S. 412, 421-422, 98 S.Ct. 694, 700-701, 54 L.Ed.2d 648, 657 (1977) that a district court should only grant attorneys' fees to a prevailing Title VII defendant upon a finding that plaintiff's actions were "frivolous, unreasonable, or without foundation, even though not brought in subjective bad faith." Furthermore:

> In applying these criteria, it is important that a district court resist the understandable temptation to engage in post hoc reasoning by concluding that, because a plaintiff did not ultimately prevail, his action must have been unreasonable or without foundation. This kind of hindsight logic could discourage all but the most airtight claims, for seldom can a prospective plaintiff be sure of ultimate success. No matter how honest one's belief that he has been the victim of discrimination, no matter how meritorious one's claim may appear at the outset, the course of litigation is rarely predictable. Decisive facts may not emerge until discovery or trial. The law may change or clarify in the midst of litigation. Even when the law or the facts appear questionable or unfavorable at the outset, a party may have an entirely reasonable ground for bringing suit.
>
> *Id.*

Though the rights protected by Title VII are of constitutional dignitary rather than statutory and economic (See *Eddy v. Colonial Life Insurance*, 59 F.3d 201, 205 (1995)), ERISA and Title VII serve the same purpose – to allow a plaintiff to bring a claim to protect his or her rights. A finding that a plaintiff should pay a prevailing defendant's attorneys' fees would be wholly unjust except in the most frivolous, bad faith claims.

This Court acknowledged in *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 147, 105 S.Ct. 3085, 3093, 87 L.Ed.2d 96, 106 (1985) that "in answer to a possible concern that attorneys' fees might present a barrier to maintenance of suits for small claims, thereby risking underenforcement of beneficiaries' statutory rights, it should

be noted that ERISA authorizes the award of attorneys' fees."

The Seventh Circuit's cavalier attitude toward fee-shifting under ERISA has broad implications that will effect every future ERISA claimant. If this Court allows the Seventh Circuit ruling that two individual plaintiffs should be responsible for paying the Respondent's attorneys' fees under the circumstances of this case, it will end forever the ability of a single employee or small group of employees from pursuing a claim under ERISA. The potential cost of an adverse result in litigation would be too great. This Court should confirm the majority of Circuits, finding that no such presumption should be granted.

CONCLUSION

For the foregoing reasons, Petitioners respectfully request that the Court grant this Petition for Writ of Certiorari.

Respectfully submitted,

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In the

United States Court of Appeals

for the Seventh Circuit

Nos. 02-2765 & 02-3871

RICHARD B. HELFRICH and DANIEL B. NELSON,

Plaintiffs-Appellants,

v.

CARLE CLINIC ASSOCIATION, P.C.

Defendant-Appellee.

Appeals from the United States District Court
for the Central District of Illinois
No. 99-2232 – **Michael P. McCuskey**, *Judge.*

ARGUED APRIL 18, 2003 – DECIDED MAY 12, 2003

Before EASTERBROOK, KANNE, and DIANE P. WOOD, *Circuit Judges.*

EASTERBROOK, *Circuit Judge.* Carle Clinic Association claims to be one of the nation's largest medical-practice groups. See <http://carle.com>. Together with the Carle Foundation, it operates several clinics plus the hospital affiliated with the University of Illinois in Urbana-Champaign. Carle promised employees (including physicians) a pension that could be as large as 50% of average earnings. Doctors Richard Helfrich and Daniel Nelson learned to their dismay, however, that the total annual pension under Carle's defined-benefit plan cannot exceed

$160,000. Paying more would cost the plan its "tax-qualified" status, which allows Carle to deduct pension expenses and employees to defer until retirement all taxes on the value of this fringe benefit. See 26 U.S.C. §§ 401(a), 415. The cap changes with the cost of living; $160,000 is close enough for current purposes. It is less than the pension that Helfrich and Nelson believed had been promised, and when the plan refused to pay more they filed this suit under §502(a) of the Employee Retirement Income Security Act, 29 U.S.C. §1132(a). Observing that the plan's terms explicitly restrict payouts to a level consistent with retaining tax advantages, the district court granted summary judgment for Carle. Later it ordered plaintiffs to reimburse Carle for the legal expense it had incurred in defending the suit.

Plaintiffs' principal contention on appeal is that summaries Carle handed out to its employees override the terms of the plan. Every pension plan must publish a summary plan description, and conflicts between this document and the plan itself are resolved in favor of the summary plan description (unless it alerts the reader to look for additional terms in the full plan). See, e.g., *Mathews v. Sears Pension Plan,* 144 F.3d 461, 466 (7th Cir. 1998). Plaintiffs want us to extend this rule to other descriptive material. They did not make such an argument in the district court (relying there on estoppel, which we discuss below); and plaintiffs' argument, like this whole suit, reflects confusion between the employer and the plan, which under ERISA is a separate trust. Plans can control the contents of summary plan descriptions, which they prepare (with, one hopes, a degree of care appropriate to the reliance they engender and the legal consequences they carry). Plans cannot control what miscellaneous

recruiters and personnel managers may say, nor does even a large employer's human-resources staff draft descriptions with the precision that the plan itself will do – for the employer knows that its staff can refer to the summary plan description. Because ERISA requires plans to prepare summary plan descriptions, and because their content is within the plan's control, it makes sense to give these documents legal effect when relied on. Employer-prepared summaries, by contrast, have no footing in ERISA and could not be enforced against the plan without disregarding the boundary between two distinct entities: the plan and the employer. Blurring that line is what plaintiffs hope to achieve, and they have taken their own view to heart by suing only the employer. Claims based on the plan (or the summary plan description) must be enforced against the plan, which is not a party. Yet Carle makes nothing of this omission, and §1132(a) does not make federal jurisdiction depend on the plan's inclusion as a defendant. It is enough if the plaintiff is a plan participant and makes a claim for benefits. Still, plaintiffs' decision not to sue the plan reveals their working assumption that the plan and the employer are indistinguishable. ERISA does not operate that way.

One summary plan description is in the record. This document, dated October 1996, is 21 single-spaced pages. It fully describes the cap required by statute as a condition of tax deferral. The three documents that plaintiffs call "summaries" do not look remotely like summary plan descriptions and must have been prepared by Carle rather than by the plan. "Summary I" is a single-page handout; "Summary II" is a brochure that covers all of Carle's fringe benefits in the equivalent of two letter-sized pages; and "Summary III," a section of Carle's employee handbook,

though longer (at 15 pages), covers many topics in addition to the pension formula. None of the three summaries alerts employees to the $160,000 cap on tax-qualified plans, most likely because the latest of the three dates from 1981. Ever since ERISA's enactment in 1976, the Carle plan has provided that benefits will not exceed what tax-qualified plans can provide. Congress amended the Internal Revenue Code in 1986 to create the limit (originally $90,000 but lifted to $160,000 under a formula enacted in 1991), and pre-1986 brochures were unlikely to describe future legislation.

Now if a summary plan description from 1981 had omitted mention of a rule (the plan's provision that no benefit costing the plan its tax-qualified status would be paid) that had a potential to curtail retirement income, plaintiffs might have a better position. But the record does not contain any summary plan description preceding 1996. Plaintiffs complained at oral argument that the district court had blocked their discovery into this subject, but counsel admitted that he had not sought documents of this kind. Instead plaintiffs noticed several depositions of plan officials, and the district judge stopped this process as burdensome because nothing that any plan official could say about the handling of Helfrich's or Nelson's demands for larger pensions would affect the proper disposition of the suit, which depends on the validity of the plan itself. Plaintiffs' counsel then earned the district judge's enmity by noticing *another* set of depositions, showing that he would do what he could to evade the judge's ruling. The judge did not abuse his discretion in curtailing plaintiffs' efforts to take depositions; and plaintiffs did not seek production of the kind of documents that could assist them (or serve requests for admissions about the nature and

contents of earlier summary plan descriptions). Maybe counsel knew that there is no helpful document waiting to be found; Helfrich was for a time chairman of Carle's board and a member of its pension committee, so his files may well contain whatever relevant documents the plan distributed.

So the rule that summary plan descriptions, if relied on, trump the plan itself does not assist plaintiffs. And, as we have concluded that this rule should not be extended to documents prepared by the employer, it follows that the same contention under the banner of "estoppel" fares no better. The doctrine that the summary plan description prevails over the plan is a *form* of estoppel; to establish the limits of this doctrine is to establish the limits of estoppel. No matter what label applies, documents prepared by an employer do not supersede those documents that establish the terms of a pension plan. Whether, and to what extent, estoppel is available with respect to welfare benefit plans under ERISA is an issue on which the judiciary has not come to rest, compare *Frahm v. Equitable Life Assurance Society,* 137 F.3d 955, 961 (7th Cir. 1998), with *Shields v. Teamsters Pension Plan,* 188 F.3d 895 (7th Cir. 1999), but with respect to pension plans (which by statute must be very formal) the only variance that any court has allowed depends on the plan's own writings, such as summary plan descriptions. See, e.g., *Downs v. World Color Press,* 214 F.3d 802, 805-06 (7th Cir. 2000); *Krawczyk v. Harnischfeger Corp.,* 41 F.3d 276, 280 (7th Cir. 1994); *Shields,* 188 F.3d at 900 n.3. And we cannot imagine a good claim of estoppel that would require a plan to forfeit the tax benefits on which its actuarial soundness relies. Plaintiffs' position, if accepted, would cost Carle, their co-workers, and themselves considerable

sums in taxes. Helfrich estimated before the case began that, under his position, Carle would need to contribute about $20 million extra to the plan; Carle also would lose tax deductability of past and future contributions, costing it (and thus its physician-owners) millions more. It is unclear whether plaintiffs would be winners; that depends on whether the increase in pension benefits would be enough to cover their tax obligations. Most other current and former Carle employees – those not affected by the cap because their annual earnings were less than $320,000 – would be certain to lose because they would suffer tax consequences without offsetting gains. Overriding the plan's terms to achieve that dubious end is not a proper function of an equitable doctrine.

One might imagine an argument that, although the existing plan must respect the statutory rules for maintaining tax benefits, Carle should be obliged to create another plan that is not tax-qualified and brings pensions up to the promised level. Cf. *Bartholet v. Reishauer A.G. (Zurich),* 953 F.2d 1073 (7th Cir. 1992). Yet although plaintiffs hint at such an argument they do not make it expressly – perhaps because it has no footing in the three "summaries" on which they rely. These documents describe two plans: the non-contributory defined-benefit plan at issue here, and a defined-contribution plan in which employees could elect to participate. An argument for creating still a third plan, limited to Carle's best-paid physicians, has no support in the documentation. Moreover, because plaintiffs have not made this argument explicit, Carle was not put on notice of the need to discuss its effects. Would such a plan limited to well-paid employees jeopardize the tax benefits for the rest? Would it have other adverse consequences? These are subjects that we

need not explore given plaintiffs' sketchy argument. And if the contention were cast as a demand for cash from Carle without a plan, it is hard to see why employers should insure their employees against legislative change. But for the amendments to the tax code, even the unguarded language of the "summaries" would have held. Many people are disappointed, and their fortunes affected, by statutory change; this does not imply that some private party must step in to undo the effects of the legislation. The "summaries" described extant pension plans; they did not include promises to protect employees from the transition effects of statutory change.

As for attorneys' fees: the district court did not abuse its discretion in concluding that Carle, the prevailing party, is entitled to recompense under 29 U.S.C. § 1132(g)(1), which says that "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." Nor did the district judge err in concluding that fees in the range of $160,000 are reasonable, given the stakes of the case: a loss would have cost Carle $20 million or more and had awful tax consequences for many current and former employees. Carle retained ERISA specialists to protect its interests; this was a prudent step. (Plaintiffs stress that they hired less expensive lawyers. The difference shows. You get what you pay for.)

Unfortunately, however, the district judge did not exercise the billing judgment that is essential in all fee-shifting cases. Carle sought compensation for all legal time and expenses racked up during the suit's pendency. That included, for example, about $885 billed to Carle for the expense of preparing a press release describing the suit and $95 for the time one lawyer devoted to preparing an application for admission to the bar of the United

States District Court for the Central District of Illinois. Press releases are not part of a legal defense (even if the client elects to have the drafting done by lawyers), and admission to the local bar would have a benefit outlasting this case. Time devoted to exploration of insurance issues also should not be shifted to the plaintiffs; it is no concern of this litigation how things happen behind the scenes in the event the plaintiffs prevail. The district court should eliminate these items on remand and review the remaining charges to see whether fee-shifting is appropriate with respect to each kind of service rendered. Carle is entitled to recover the cost of legal defense (including the cost of preparing a budget, a normal incident in any substantial suit), but not legal expenses that do not produce a defense against the plaintiffs' claims. On balance, however, the tab will go up – for although a few items must be subtracted, the cost of defending Carle on this appeal must be added. When fees have been awarded in the district court on the authority of a fee-shifting statute, the costs of appellate work are automatically shifted. *Commissioner of INS v. Jean,* 496 U.S. 154 (1990). The district court should determine, and award, the legal fees that Carle incurred in defending its judgment.

The decision on the merits is affirmed. The award of attorneys' fees is vacated, and that subject is remanded for further proceedings consistent with this opinion.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS
Urbana Division

RICHARD B. HELFRICH, M.D., and DANIEL B. NELSON, M.D.,	)	
Plaintiffs,	)	
v.	)	**Case No. 99-2232**
CARLE CLINIC ASSOCIATION,	)	
Defendant.	)	

REPORT AND RECOMMENDATION

(Filed Apr. 3, 2000)

In September 1999, Plaintiffs, Richard B. Helfrich, M.D., and Daniel B. Nelson, M.D., filed a Complaint (#1) against Defendant Carle Clinic Association (hereinafter "Carle"), alleging violations of the Employment Retirement Income Security Act (29 U.S.C. § 1100, *et seq.*) (hereinafter "ERISA") and breach of contract. In December 1999, Defendant filed a Motion To Dismiss (#5) and Plaintiffs filed a Motion for Extension of Time To Respond to Defendant's Motion To Dismiss (#8). These two motions are now before the Court. After reviewing the parties' pleadings and memoranda, this Court recommends, pursuant to its authority under 28 U.S.C. § 636(b)(1)(B), that Defendant's Motion to Dismiss (#5) be **DENIED** and Plaintiffs' motion for extension (#8) be vacated as **MOOT**.

I. Background

Plaintiff Helfrich began working at Carle in 1969 and retired in 1997. Plaintiff Nelson began working at Carle in 1975 and still works there. Their complaint alleges that when they were hired, Carle promised them certain retirement benefits that would accrue if they agreed to work for Carle. Carle gave each Plaintiff two brochures (titled "Carle Clinic Association Fringe Benefits for Doctors" and "Money for Your Retirement – or Sonner") that described the specifics of the qualified pension plan. (Complaint, #1, p. 2.) The brochure stated as follows:

> Physicians become eligible for the Basic Plan on October 1 following one year of service. Maximum retirement benefits of 50% of the average income of the highest consecutive five years of the last fifteen years are paid to those physicians after 65 with 30 years of service. Lesser amounts are paid to those retiring early and/or with less than 30 years of service. The usual retirement payment options are available. Full vesting occurs after 10 years of employment and various options are available for those terminating employment after 10 years but prior to age 65.

Complaint, #1, p. 3. (The retirement benefits described in the brochures will be referred to hereinafter as the "original Plan.")

In October 1994, Carle changed the retirement plan. Plaintiffs allege that the revised plan (hereinafter the "restated Plan") resulted in a reduction in Plaintiffs' retirement benefits. (Complaint, #1, pp. 3-4.) In 1996, after revising the plan, Carle offered plan members a lump sum payment to compensate for the reduction in benefits. In return for the payment, plan members had to agree to

release Carle from further liability under the original Plan. Plaintiffs refused to sign a release and did not receive a lump sum benefit from Carle.

When Plaintiff Helfrich retired in 1997, he received a substantially smaller benefit than he would have under the original Plan. Although Plaintiff Nelson has not yet retired, he has been informed that his retirement benefits will be calculated using the restated Plan. Both Plaintiffs have petitioned the Carle Board of Governors (hereinafter the "Board") for the retirement benefits that Carle promised in the original Plan. The Board has refused to pay Plaintiffs those retirement benefits.

In September 1999, Plaintiffs filed this suit. Count I alleges that Defendant changed Plaintiff Helfrich's retirement benefits in violation of Sections 1053(a)(3)(C), 1054(g), and 1082(c)(8) of ERISA (29 U.S.C. §§ 1053(a)(3)(C), 1054(g), 1082(c)(8)). Count II alleges that Defendant's change from the original Plan to the restated Plan breached the employment contract between Helfrich and Carle. Counts III and IV allege the same claims with regard to Plaintiff Nelson.

Defendant's motion to dismiss alleges that (1) the ERISA counts (Counts I and III) are barred because Plaintiffs failed to exhaust their administrative remedies; and (2) ERISA preempts the state law breach of contract claims (Counts II and IV).

In December 1999, Plaintiffs filed a Motion for Extension of Time To Respond to Defendant's Motion To Dismiss (#8), alleging that they needed time for discovery. Defendant objected on the ground that ERISA does not permit discovery outside the administrative record before responding to a motion to dismiss for a failure to exhaust administrative proceedings.

II. Standard for Motion To Dismiss

The purpose of a motion to dismiss pursuant to Rule 12(b)(6) is to test the sufficiency of the complaint, not to decide the merits of the case. *Miller v. Reebie Storage and Moving Company, Inc.*, No. 93C3986, 1993 WL 414689, *1 (N.D. Ill. 1993)). When considering a motion to dismiss, the Court must accept as true all well-pleaded factual allegations in the claim, and draw all reasonable inferences in the light most favorable to the nonmoving party. *Gutierrez v. Peters*, 111 F.3d 1364, 1368-69 (7th Cir. 1997). The Court should dismiss the claim only if the nonmoving party can prove no set of facts consistent with the allegations of the complaint that would entitle him to relief. *Turner/Ozanne v. Hyman/Power*, 111 F.3d 1312, 1319-20 (7th Cir. 1997).

III. Discussion

A. ERISA Claims

Defendant argues that the Court should dismiss the ERISA claims because Plaintiffs failed to exhaust administrative proceedings.

A beneficiary of an ERISA plan may bring a civil action to obtain appropriate equitable relief to redress violations of ERISA or to enforce any provisions of ERISA or the terms of an ERISA plan itself. 29 U.S.C. § 1132(a)(3). ERISA is silent, however, as to whether a plaintiff must exhaust administrative remedies as a prerequisite to initiating such an action. Unless statutorily mandated, the decision to require exhaustion as a prerequisite to bringing suit is a matter within the discretion of the trial court, subject to review on appeal under the clear

abuse of discretion standard. *Powell v. A.T. & T. Communications Inc.*, 938 F.2d 823, 825 (7th Cir. 1991). Abuse of discretion means a serious error of judgment, such as reliance on a forbidden factor or failure to consider an essential factor. *See Kasper v. Board of Election Comm'rs*, 814 F.2d 332, 339 (7th Cir. 1987).

Although ERISA does not contain an express exhaustion requirement, courts uniformly have concluded that the comprehensive administrative scheme implies a requirement that participants exhaust their administrative remedies before commencing suit in federal court. *See Fallick v. Nationwide Mutual Ins. Co.*, 162 F.3d 410, 418 (6th Cir. 1998) (citing cases from all 10 circuits that have addressed the issue). Exhaustion of administrative remedies is appropriate where it is necessary to develop a full factual record or to take advantage of the agency's expertise. *Janowski v. International Brotherhood of Teamsters, Local 710 Pension Fund*, 673 F.2d 931, 935 (7th Cir. 1982), vacated on other grounds, 103 S.Ct. 3565 (1983).

Nevertheless, assuming the exhaustion doctrine should be applied to ERISA cases, the doctrine is not absolute. *Id.* Where the issue is merely a question of statutory interpretation, exhaustion is not required. *Id.* at 935. Exhaustion of administrative procedures is also not required where the administrative procedure would be futile or would be a useless gesture. *See Powell*, 938 F.2d at 826.

This Court recognizes the strong federal policy encouraging private resolution of ERISA-related disputes. *See Kross v. Western Elec. Co.*, 701 F.2d 1238, 1244 (7th Cir. 1983). The Seventh Circuit has mandated the application of the exhaustion doctrine to statutory claims for

breach of a fiduciary duty under ERISA. *Id.* In addition, by mandating internal claims procedures (*see* 29 U.S.C. §§ 1133, 2560.503-1), Congress apparently intended to minimize the number of frivolous lawsuits, promote consistent treatment of claims, provide a nonadversarial dispute resolution process, and decrease the cost and time of claims settlement. *See Makar v. Health Care Corp. or the Mid-Atlantic*, 872 F.2d 80, 83 (4th Cir. 1989). In short, Congress intended plan fiduciaries not federal courts, to have primary responsibility for claims processing. *Kross*, 701 F.2d at 1244.

Nevertheless, in this case, it is not necessary to develop a full factual record of the administrative process or to take advantage of the agency's expertise. This case does not involve claims processing nor are Plaintiffs requesting a review of the amount of their benefit under the restated Plan. Plaintiffs do not assert that their benefits have been calculated incorrectly under the restated Plan or that they are entitled to greater benefits under the restated Plan. There appear to be no factual disputes as to what the restated Plan requires or provides, or to the correctness of the plan administrator's interpretation of that Plan. Instead, the issues in this suit are related to the question of whether Plaintiffs are entitled to the amount they would have received under the original Plan and whether Defendant had a right to unilaterally, and without compensation, change the terms of their employment contract.

Dismissing this case to require exhaustion of administrative procedures would not be efficient, would not serve justice, and would likely prove futile. The plan administrator asserted that the IRS and ERISA control the limits of what Carle is allowed to pay to Plaintiffs under the restated Plan.

That will not change no matter how Plaintiffs frame a request for administrative review. Furthermore, Plaintiffs are not asserting rights under the restated Plan. A plan administrator has no authority to invalidate an amendment to the plan, only to interpret the plan as it exists under the facts and circumstances of the specific claim. *See Gould v. GTE North Incorporated,* 40 F.Supp. 2d 434, 440 (W.D. Mich. 1999), vacated on other grounds, 68 F.Supp. 2d 842. Thus, the plan administrator had no authority to grant Plaintiffs relief on their claim.

In its Memorandum of Law in Support of Motion To Dismiss (#6), Defendant stated that the restated Plan requires that a claimant who desires a review of the Committee's determination must filed a written request for a review with the Plan Administrator. (Plan, § 6.06(c-d).) This is not persuasive; again, Plaintiffs do not seek a review of the Committee's determination of their retirement benefit amount *under the restated Plan.* Plaintiffs simply disagree that the restated Plan is the sole source of their entitlement to retirement benefits. Defendant cannot complain that administrative procedures were not exhausted when those procedures do not purport to address the issues that Plaintiffs dispute. *See Huppeler v. Oscar Mayer Foods Corp.*, No. 93-C-370-S. 1993 WL 730699, *2-3 (W.D. Wis. 1993), aff'd, 32 F.3d 245 (7th Cir. 1994), *cert denied*, 115 S.Ct. 1253 (1995).

Although the Court declines to require Plaintiffs to exhaust administrative proceedings in this case, a brief review of the record before the Court shows that Plaintiffs apparently have indeed attempted to exhaust administrative proceedings. The only support for Defendant's position appears to be an affidavit from Carle's Plan Administrator, Tara Swearingen, stating that Plaintiffs never presented a

claim to her based on their contention that the restated Plan had reduced their accrued benefits. (See affidavit executed on November 23, 1999.) However, Plaintiff Helfrich did formally ask the Board how his retirement benefits would be handled, referring to his understanding under the original Plan. (See Helfrich's letter to Robert J. Turngren, dated August 16, 1996.) In his September 4, 1998, letter to Plaintiffs' attorney, Robert Parker, Carle's Chief Executive Officer, stated that "Dr. Helfrich's request is being treated as a formal claim for benefits" and had been forwarded to Melody Henegar, the Benefits Manager, for review. In addition, in a letter dated December 11, 1998, Plaintiffs' attorney described the materials that Helfrich provided to Swearingen, which clearly indicated that he was seeking the amount promised under the original Plan (as described in the brochures). Furthermore, in his letter dated February 24, 1999, Plaintiffs' attorney requested review of the Plan Administrator's decision and again described the basis for their claim, referring to the brochures describing the original Plan. Although the decision to deny the motion to dismiss does not require a review of the record, the Court observes that the record does not support Defendant's argument.

Accordingly, the Court recommends denying Defendant's Motion To Dismiss the ERISA claims.

B. Breach of the Contract Claims

Defendant argues that Plaintiffs' breach of contract claims are preempted by ERISA because they relate to an employee benefit plan. 29 U.S.C. § 1144(a); *Tolle v. Carroll Touch, Inc.*, 977 F.2d 1129, 1136 (7th Cir. 1993) (holding that ERISA preempts state law breach of contract claims

that rely "exclusively on the terms" of an employee benefit plan). However, unlike *Tolle*, here Plaintiffs do not rely exclusively on the terms of the employee benefit plan. In fact, they do not contend that the terms of the restated Plan are even relevant to their claim. Defendant's reliance on *Panaras v. Liquid Carbonic Industries Corp.*, 74 F.3d 786 (7th Cir. 1996) (recognizing that ERISA preempts all state claims for plan benefits), is also inapt. In Defendant's reliance on *Panaras v. Liquid Carbonic Industries Corp.*, 74 F.3d 786 (7th Cir. 1996) (recognizing that ERISA preempts all state claims for plan benefits), is also inapt. In *Panamas*, the plaintiff contended that the employer's notification and disclosure duties under ERISA were implied terms of the employment contract. Again, Plaintiffs do not contend that the terms of the restated Plan are relevant to their claim, other than as evidence that Defendant changed the terms of their employment contract.

Based on the appropriate standard for a motion to dismiss, the Court concludes that Plaintiffs' breach of contract claims are not based solely on the terms of the ERISA plan. Accordingly, the Court recommends denying Defendant's motion to dismiss.

IV. Summary

For the reasons set forth above, this Court recommends that Defendant's Motion To Dismiss (#5) be **DENIED**. Consequently, Plaintiffs' Motion for Extension of Time To Respond to Defendant's Motion To Dismiss (#8) should be vacated as **MOOT**. The parties are advised that any objection to this recommendation must be filed in writing with the clerk within ten (10) working days after

being served with a copy of this Report and Recommendation. *See* 28 U.S.C. § 636(b)(1). Failure to object will constitute a waiver of objections on appeal. *Video Views, Inc. v. Studio 21, Ltd.*, 797 F.2d 538 (7th Cir. 1986).

ENTER this 3rd day of April, 2000.

/s/ David G. Bernthal
DAVID G. BERNTHAL
UNITED STATES
MAGISTRATE JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
DANVILLE/URBANA DIVISION

RICHARD B. HELFRICH, M.D., AND DANIEL B. NELSON, M.D., Plaintiffs,	)	
v.	)	No. 99-2232
CARLE CLINIC ASSOCIATION, Defendant.	)	

ORDER

(Filed Aug. 28, 2000)

On September 30, 1999, Plaintiffs Richard B. Helfrich, M.D. and Daniel B. Nelson, M.D. filed a four-count complaint against Defendant Carle Clinic Association ("Carle"). Counts I and III allege violations of the Employment Retirement Income Security Act (29 U.S.C. § 1100 *et seq.*) ("ERISA"). Counts II and IV allege breach of contract under state law. On December 3, 1999, Carle filed a Motion to Dismiss (#5) that complaint. In that motion, Carle argued that Plaintiffs' ERISA claims should be dismissed for failure to exhaust administrative remedies, and that Plaintiffs' state law breach of contract claims are preempted by ERISA. In response, Plaintiffs filed a Motion for Extension of Time in Which to Respond to Defendant's Motion to Dismiss (#8).

On April 3, 2000, the Magistrate Judge entered a Report and Recommendation recommending that Carle's Motion to Dismiss be denied in full, and that Plaintiffs'

Motion for Extension be denied as moot. On April 19, 2000, Carle filed an objection to the Magistrate Judge's recommendation. On May 4, 2000, Plaintiffs responded to that objection. Carle filed a reply to that response on May 17, 2000.

The court has conducted a careful *de novo* review of this matter. In doing so, the court has considered all the relevant filings by the parties regarding the original motions, the Magistrate's Report and Recommendation, the parties' subsequent filings, and the relevant case law. Based on this review, the court accepts the Report and Recommendation in part. Specifically, the court agrees that Counts I and III of Plaintiffs' complaint should not be dismissed for failure to exhaust administrative remedies. As to those claims, the court relies on the reasoning and analysis set forth in the Report and Recommendation and adds no further commentary. However, for the reasons that follow, the court finds contrary to the Report and Recommendation that Count II and IV are preempted by ERISA and should be dismissed.

BACKGROUND

The court draws the following facts from the complaint. Plaintiff Helfrich began working for Carle as a physician in 1969 and retired in 1997. Plaintiff Nelson, also a physician, began his employment with Carle in 1975 and still works there. At the time of hiring, Carle promised each Plaintiff that certain retirement benefits would accrue so long as he continued to work there.

In 1994, however, Carle changed the retirement plan. Under the revised plan, Plaintiffs would receive

smaller benefits than originally promised. In 1996, Carle offered Plaintiffs along with other plan members a lump sum payment to compensate them for the reduction in benefits. In return for that payment, plan members were to release Carle from liability under the original plan. Plaintiffs refused to accept this offer, and now seek the benefits originally promised them.

When Plaintiff Helfrich retired in 1997, he received smaller benefits than he would have under the original plan. Plaintiff Nelson has not yet retired, but he has been informed that his retirement benefits will be calculated under the revised plan. Both Plaintiffs petitioned Carle's Board of Governors for the retirement benefits promised under the original plan. The Board of Governors, however, has denied that request. As a result, Plaintiffs brought this suit to recover the benefits promised under the original plan.

ANALYSIS

In Counts I and III, Plaintiffs assert that Carle wrongfully modified their retirement benefits plan in violation of 29 U.S.C. §§ 1053(a)(3)(C), 1054(g), & 1082 (c)(8). In Counts II and IV, they assert that this modification constituted a breach of their employment contracts with Carle. Carle argues that ERISA preempts Plaintiffs' state law breach of contract claims. This court agrees.

ERISA provides extensive regulation of employee benefit plans. In doing so, ERISA expressly preempts state law claims relating to such plans. Specifically, section 1144(a) states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter

relate to any employee benefit plan." 29 U.S.C. § 1144(a). The Supreme Court has interpreted section 1144(a) preemption broadly, considering its language to be "deliberately expansive." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987); *see also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (finding that ERISA preempts all state laws which have a "connection with or reference to" employee benefit plans). Similarly, the Seventh Circuit has determined that ERISA "displaces all state laws 'within its sphere, even including state laws that are consistent with ERISA's substantive requirements.'" *Tolle v. Carroll Touch, Inc.*, 977 F.2d 1129, 1136 (7th Cir. 1992) (*quoting Metropolitan Life Ins. Co. v. Mass*, 471 U.S. 724, 739 (1985)). Consequently, ERISA preempts state law tort or contract claims that are essentially suits for benefits. *Lister v. Stark*, 890 F.2d 941, 945-46 (7th Cir. 1989) (finding that ERISA preempted participant's claims for fraud and breach of oral contract to modify pension plan).

The Seventh Circuit broadly stated the preemption rules in *Bartholet v. Reishauer A.G.*, 953 F.2d 1073 (7th Cir. 1992). In *Bartholet*, the plaintiff brought a breach of contract action based upon an employer's promise that a certain type of plan would be created. The court concluded that the dispute was based on ERISA, even if consideration of technical ERISA requirements and adjustment of plan assets were unnecessary. *Bartholet*, 953 F.2d at 1076. In so holding, the court remarked that "Congress has blotted out (almost) all state law on the subject of pensions, so a complaint about pensions rests on federal law no matter what label its author attaches." *Bartholet*, 953 F.2d at 1075.

Here, Plaintiffs' entire claim to benefits is predicated on the existence of the original plan and their entitlement to benefits under that plan. The core of both claims is that Carle promised one set of pension benefits, and now wants to deliver something else. Moreover, Plaintiffs seek the same relief for both claims, namely, that Carle pay them the benefits originally promised. Thus, the state law breach of contract claims unquestionably relate to the benefit plan under section 1144(a).

Plaintiffs have no choice but to acknowledge that the broad scope of ERISA preemption encompasses their state law breach of contract claims. Thus, they do not argue that their state law claims are unrelated to the pension plan. Instead, they argue that ERISA's preemption does not apply because the pension plan promised by Carle is really an "excess benefit plan" under 29 U.S.C. § 1003(b). Section 1003(b) provides that ERISA does not apply to any employee benefit plan if that "plan is an 'excess benefit plan' . . . and is unfunded." 29 U.S.C. § 1003(b)(5). An excess benefit plan is one the employer maintains "solely for the purpose of providing benefits for certain employees in excess of the limitation on contributions and benefits imposed by Section 415 [of the Code] on plans to which that section applies without regard to whether the plan is funded." 29 U.S.C. § 1002(36). When an excess benefit plan is unfunded, none of the provisions of ERISA apply. 29 U.S.C. § 1003(b)(5); *Gamble v. Group Hospitalization & Med. Serv., Inc.*, 38 F.3d 126, 128 (4th Cir. 1994). Under those circumstances, ERISA does not preempt and state law applies. *See Olander v. Bucyrus-Erie Co.*, 187 F.3d 599, 604 (7th Cir. 1999).

There are several problems with Plaintiffs' argument that their claims are exempt from ERISA preemption. In the first place, an excess benefit plan must be unfunded for ERISA not to apply. 29 U.S.C. § 1003(b)(5). Plaintiffs' complaint, however, refers to the original plan as "funded," which forecloses any argument that their state law claims avoid preemption under section 1003(b)(5). But perhaps more troubling is that if the original or revised plans are in fact unfunded excess benefit plans as Plaintiffs assert, ERISA would not govern this dispute. In that case, Plaintiffs would have no cause of action under ERISA to recover the originally promised benefit plan, but would be confined to their state law breach of contract claims. *See Gamble*, 38 F.3d at 131-32 (affirming dismissal for lack of subject matter jurisdiction over claims seeking benefits under excess benefits plan).

Simply put, Plaintiffs cannot have it both ways. They cannot invoke ERISA's protection to enforce the original plan and then try to avoid preemption by arguing that ERISA does not apply. Thus, the court agrees with Carle that ERISA preempts Plaintiffs' state law breach of contract claims, and therefore dismisses Counts II and IV with prejudice.

CONCLUSION

The court GRANTS in part, and DENIES in part Carle's Motion to Dismiss (#5). Specifically, the court dismisses Counts II and IV with prejudice. However, for the reasons set forth in the Report and Recommendation, the court DENIES Carle's motion as to Counts I and III. Furthermore, because Plaintiffs' Motion for

Extension of Time in Which to Respond to Defendant's Motion to Dismiss (#8) addressed the motion only as to Counts I and III, the court accepts the Magistrate Judge's recommendation to DENY it as MOOT. This case is referred back to the Magistrate Judge for further proceedings.

ENTERED this 25th day of August, 2000.

/s/ Michael P. McCuskey
MICHAEL P. McCUSKEY
U.S. DISTRICT JUDGE

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS
DANVILLE/URBANA DIVISION

RICHARD B. HELFRICH, M.D., and DANIEL B. NELSON, M.D.,	)	
Plaintiffs,	)	
vs.	)	**Case No. 99-2232**
CARLE CLINIC ASSOCIATION,	)	
Defendant.	)	

ORDER

(Filed Jun. 4, 2002)

On September 30, 1999, Plaintiffs Richard B. Helfrich ("Helfrich") and Daniel B. Nelson ("Nelson") filed a four-count Complaint against Defendant Carle Clinic ("Carle"). Counts I and III allege violations of the Employee Retirement Income Security Act (ERISA). Counts II and IV allege breach of contract under state law. Carle filed a Motion to Dismiss (#5) on December 3, 1999. In an Order (#27) entered August 28, 2000, this court granted the motion to dismiss as to Counts II and IV, but denied the motion with respect to Counts I and III. Plaintiffs' ERISA claims allege that Carle unlawfully and retroactively reduced their accrued pension benefits. On September 4, 2001, Plaintiffs filed a Motion for Summary Judgment (#59). On September 13, 2001, Carle filed its Motion for Summary Judgment (#63). Both parties have also filed

Motions to Strike (#67 & #68). For the reasons that follow, the Motions to Strike (#67 & #68) are DENIED, Plaintiffs' Motion for Summary Judgment (#59) is DENIED, and Carle's Motion for Summary Judgment (#63) is GRANTED.

FACTS

Plaintiffs are physicians employed by Defendant Carle. Helfrich began his employment with Carle in 1969 and continued working there until his retirement in 1997. During his employment, Helfrich served on Carle's Board of Directors, both as a member and Chairman. Helfrich also served on the pension committee from 1983 to 1989. Nelson began his employment in 1977 and began disability leave on June 17, 2001.

Beginning in 1946, Carle maintained a pension plan ("the Plan") for its employees. Both Helfrich and Nelson are participants in the Plan. The Preamble of the Plan provides:

> The primary purpose of this Plan is to provide for the retirement of eligible Employees of the Employer who became Participants in this Plan. It is intended that this Plan, together with the Trust Amendment, comply with the Employee Retirement Income Security Act of 1974, as amended and the Internal Revenue Code of 1986, as amended, and the Plan shall be so interpreted to accomplish this end.

Section 1.03 of the Plan further provides that the Plan should be interpreted in such a manner that "causes the Plan to comply with all applicable requirements of ERISA, the Internal Revenue Code, and the regulations thereunder."

Section 4.07 of the Plan provides that "any benefits payable under the Plan shall be subject to the limitations of this Section," including the Section 415 limitations of the Internal Revenue Code.

Pursuant to the Plan's claims procedure, an employee "may submit a written claim to the Committee describing the benefit to which he believes he is entitled. Upon receipt of the executed form or other written notice of claim, the Committee shall determine the benefits, if any, payable to the claimant." Section 6.13 of the Plan provides that the Committee may designate persons other than named fiduciaries to carry out its responsibilities under the Plan, including the consideration of participants' claims for benefits. The claimant is entitled to written notice of the decision providing the specific reason for the benefit denial, specific references to pertinent Plan provisions, a description of additional material or information necessary for the claimant to perfect the claim, and information about the review process. If the claimant requests review of the denial of benefits, the plan administrator reviews the disputed claim and renders a decision.

The Plan was amended several times – in 1972, 1976, 1989, and 1994. The 1989 Amendment set forth for the first time the following formula for pension benefits:

> [T]he monthly amount of the Normal Retirement Pension on a single-life basis shall be equal to (a) minus (b):
>
> (a) 1.67% times the Participant's Average Monthly Compensation multiplied by his years of Credited Service to a maximum of 30 years.
>
> (b) The Participant's Social Security Offset Allowance.

Carle also issued several documents detailing the benefits offered to its employees, including pension benefits. The first of these was issued on November 22, 1976, and was entitled "Carle Clinic Association Professional Staff Benefits." This document stated that the pension plan provided "50% of average income of the highest consecutive five of the last fifteen years for retirement" and "fully vested at ten years." Carle also distributed a document entitled "Carle Clinic Association Fringe Benefits for Doctors" in the late 1970s. This document described the pension plan as follows:

> Maximum retirement benefits of 50% of the average income of the highest consecutive five years of the last fifteen years are paid to those physicians age sixty-five with thirty years of service. Lesser amounts are paid to those retiring early and/or with less than thirty years of service. The usual retirement payment options are available. Full vesting occurs after ten years of employment.

In October 1981, Carle distributed a final document entitled "Money for Your Retirement or Sooner." This document also stated that employees retiring at age 65 with 30 or more years of service would receive "a lifetime monthly income of 50% of final average pay." Helfrich and Nelson state in affidavits that they relied upon these documents in making employment decisions, career plans, and in deciding to continue employment at Carle. Helfrich also states that he used these documents to recruit other doctors to work at Carle.

In November 1994, Helfrich wrote Carle's Board of Governors stating that there was an unfunded Carle pension liability of twenty million dollars. A group of

twenty Carle physician-employees engaged in a colloquy with the Board on this issue. On February 8, 1995, the CEO of Carle drafted a letter stating, "The Board has already acted upon the question of whether to abide by the legal pay out limits (415 limits) which have been in place since 1976. The Board has decided not to make adjustments for individuals impacted by this law." This letter was forwarded to Tara Swearingen ("Swearingen"), Carle's Plan Administrator. On February 9, 1995, Helfrich again wrote the Board claiming that Carle had a contractual obligation to pay the full pension amount to its employees. On August 2, 1995, Plaintiffs' counsel reasserted this position to Dr. Robert Parker ("Parker"), Chief Executive Officer of Carle.

On December 18, 1995, Carle approved a lump-sum payment to the group of physicians affected by § 415 limitations upon execution of a written waiver of future claims. On January 9, 1996, Parker wrote Helfrich regarding this proposed resolution. Carle paid $2 million to sixteen physicians through lump sum payments in 1996, and these physicians signed waivers of further pension benefit claims. Neither Helfrich nor Nelson accepted Carle's offer. On August 26, 1996, Helfrich wrote Robert Turngren ("Turngren"), Carle's then Chief Executive Officer, asking the Board of Directors to review its decision not to provide what Helfrich believed to be his full pension benefits. On August 16, 1996, Turngren responded by saying the Board has "no further intent to make adjustments for either the contribution caps or the 415 pay out limits."

On August 12, 1998, Helfrich sent a letter to Parker. In this letter, Helfrich claimed that in order for "promises made by Carle Clinic Association to him in the past to be

kept in the present," he was entitled to an additional $30,000 per year in pension benefits under the Plan. Helfrich offered to settle his claim with Carle in return for a lump sum payment of $400,000. The letter also threatened litigation if the dispute was not resolved within 14 days. In a letter dated September 4, 1998, Parker advised Helfrich that his letter was "being treated as a formal claim for benefits under the Carle Clinic Association Pension Plan Restated effective October 1, 1994." Parker advised Helfrich that his claim for benefits had been referred to the Benefits Manager, Melody Henegar ("Henegar"), for a recommendation to the Plan Administrator. Parker informed Helfrich's counsel that he could send "any additional information that you believe will aid the Benefits Manager in making her determination regarding Dr. Helfrich's claim for benefits." On September 14, 1998, Helfrich sent Carle a letter indicating his desire to have his claim decided through binding arbitration rather than through the Plan's administrative process.

On December 10, 1998, Swearingen, the Plan Administrator, sent a letter to counsel for Helfrich which stated:

> As Plan Administrator, I have reviewed Dr. Helfrich's claim and the information provided by Ms. Henegar in regard to his status. Information supporting your client's claim was requested by Dr. Parker's September 4, 1998, letter. Given that no new/additional information was provided, the interpretation of the plan and benefit amount stands.

On December 11, 1998, Helfrich wrote Parker to point out what he believed to be shortcomings in the decision issued by Swearingen. On January 6, 1999, Swearingen responded by stating that "[a]ll past information that was

submitted by [Helfrich] was a part of our evaluation and I can assure you, was given due consideration." On January 21, 1999, Helfrich sent a letter to Swearingen requesting additional detail regarding the denial of Helfrich's claim.

On January 29, 1999, Swearingen provided Helfrich's counsel with a letter supplementing the previous denial letter. In this letter, Swearingen stated that Helfrich was "seeking benefits unreduced by limitations imposed under the Plan. "Swearingen "concluded that Dr. Helfrich is only eligible for benefits reduced by the limitations imposed under the Plan." Swearingen went on to state that the Plan is subject to the limitations of the Internal Revenue Code of 1986 ("Code") and noted that the Plan incorporates the Code's Section 415 limitations. The specific reason for the denial was explained as follows:

> Code Section 401(a)(17) imposes certain limitations on compensation to be considered in making contributions to a tax-qualified pension plan. Under Code Section 404, employer contributions to a defined benefit plan may not exceed the amount necessary to fund a participant benefit. Additionally, Code Section 415 limits the amount of "payout" a participant may receive annually. Therefore, the Code limits both the amount of benefits a participant may receive and the amount that an employer can contribute to those benefits. The Plan incorporates both the limitations under Code Sections 401(a)(17) and 415 limitations in Sections 1.01 and 4.07, respectively.
>
> Under ERISA and the Code, the Plan must be operated in conformity with the Plan document. Under the Plan, Dr. Helfrich can only receive those benefits to which he is entitled subject to

> the limitations discussed above. The benefit calculation that was the basis of Dr. Helfrich's benefit estimate was determined under Section 4.01 of the Plan, which is subject to those limitations. Thus the previous description of the annual amount of the life annuity payable to him is accurate.
>
> If the Plan were to pay Dr. Helfrich additional amounts, whether as a lump sum of $400,000 (as you requested) or any other amounts, this would violate the provisions of the Plan because the payment or payments would be in excess of the benefit formula and Code limitations.

The letter went on to invite Helfrich to submit any additional documents concerning why this limitation would not apply and advised Helfrich of the review process under the Plan.

On February 24, 1999, Helfrich formally requested a review of the decision to deny Helfrich's claim for additional benefits. This letter referred the Plan Administrator to the "brochures prepared by the clinic, in its efforts to recruit physicians in the 1970's and 1980's." No documents were submitted for the Plan Administrator's review. On April 23, 1999, Swearingen sent Helfrich a letter indicating that she had reviewed Helfrich's request for review and "concluded that the decision that Dr. Helfrich is only eligible for benefits subject to the limitations imposed under the Plan is the correct decision." Swearingen indicated that Helfrich had chosen not to submit additional materials, and, as a result, her review was limited to those materials on which the original decision was based.

On April 27, 1999, Nelson sent a letter to Swearingen requesting a review of his pension benefits. On July 15,

1999, Swearingen informed Nelson that his request was being treated as a formal claim for benefits and that the claim had been referred to Henegar for a recommendation. Swearingen requested that Nelson provide additional information to support his claim and advised him of the claims procedure. In a letter dated July 28, 1999, Henegar informed Nelson that his claim for benefits had been denied. Henegar explained the denial as follows:

> Section 4.01 Standard Benefit Formula states that a participant shall receive on the first day of the month next following normal retirement "one and sixty-seven hundredths percent (1.67%) of the Participant's Monthly Plan Compensation Multiplied by his years of Benefit Service. . . . But the Standard Benefit Formula states, in addition, "a minimum benefit may be applicable pursuant to the last paragraph of Section 1.01(a) based on the provisions of the Plan in effect prior to this restatement. The benefit formula under this Section 4.01 does not contemplate calculating Plan benefits as you have requested.
>
> Section 1.01(a) Accrued Retirement Benefit states that "the Plan utilizes the Alternative IID (as described in IRS Notice 88-131) in order to comply with the potential conflict between the provision of Section 401(1) of the Internal Revenue Code . . . and the anti-cutback provisions contained in Section 411(d)(6) of the Internal Revenue Code." Section 1.01(a) provides an alternative calculation of benefits, but does not provide for benefits calculated in the manner you have requested.
>
> Additionally, Section 1.01(j) "Compensation" specifically limits the compensation considered for Plan purposes for a Participant to two hundred

> thousand dollars ($200,000) for any year after December 31, 1988, pursuant to Section 401(a)(17) of the Internal Revenue Code.... Similarly, in Section 4.07 *IRC § 415(b) Limitation on Benefits*, the Plan restates Internal Revenue Code limitations on the maximum amount payable under all qualified defined benefit plans maintained by an employer. Thus, your request is for benefits unreduced by Social Security or the limitations imposed under the Plan, and without regard to the specific governing Plan provisions. You are only eligible for benefits calculated pursuant to the limitation imposed under the Plan.... Therefore, your claim is denied.

The letter went on to more fully explain the applicability of these provisions to Nelson.

On August 2, 1999, Nelson submitted a request for review of the decision to deny his claim for additional benefits. In this letter Nelson stated that "Ms. Henegar's letter focuses on ERISA regulations which may or may not limit the amount of money that Carle Clinic Association is able to pay me on my retirement." Nelson also asked the following questions: (1) "How do the ERISA requirements ... prevent Carle from paying me additional funds through some non-ERISA plan?; and (2) Even if the Clinic continues to claim that ERISA prevents it from paying me the promised benefit, how does it explain the settlement that was paid to the other doctors who made the same claim back in February of 1996?". On August 12, 1999, Swearingen advised Nelson that she had received his request for review. On October 1, 1999, Swearingen advised Nelson that she had reviewed the decision to deny his claim for additional benefits and determined that the decision was appropriate. With regard to the questions

asked by Nelson, Swearingen stated that the issues "are not properly before me in my position as Plan administrator."

ANALYSIS

I. Summary Judgment Motions

A. Standard

Summary judgment is granted "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c); *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986). In ruling on a motion for summary judgment, the court must decide, based on the evidence of record, whether there is any material dispute of fact that requires a trial. *Waldridge v. American Hoechst Corp.*, 24 F.3d 918, 920 (7th Cir. 1994). In reaching this decision, the court must consider the evidence in the light most favorable to the party opposing summary judgment. *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 158-59 (1970). The burden of establishing that no genuine issue of material fact exists rests with the movant. *Jakubiec v. Cities Serv. Co.*, 844 F.2d 470, 473 (7th Cir. 1988). However, a court should not deny summary judgment simply because some facts are in dispute, or because the proffered evidence presents "some metaphysical doubt as to the material facts." *McCreary v. Libbey-Owens-Ford Co.*, 132 F.3d 1159, 1164 (7th Cir. 1997).

B. Review of the Plan Administrator's Decision Denying Benefits

The primary issue raised in both parties' motions for summary judgment is whether the decision of the Plan Administrator denying Plaintiffs' claims for benefits should be upheld. This court has previously determined that the decision of Carle's Plan Administrator is entitled to deferential review. In an Order (#45) entered May 7, 2001, this court stated as follows:

> In determining the scope of discovery which is available to the parties in this case, this court must first determine the degree of deference which the plan administrator is due from the court. "Decisions of ERISA plan administrators presumptively receive de novo review, but if the plan establishes discretionary authority then review will be deferential." *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 980 (7th Cir. 1999) (internal citations omitted). Section 6.04(b) of the Carle Clinic Association Pension Plan states that the Administrative Committee shall have the power to "construe the Plan and Trust Agreement in its discretion regarding any issues arising under the Plan, including the eligibility for an amount of any benefits due to a Participant or Beneficiary, and the Committee's construction thereof shall be final and conclusive if such construction is reasonable and made in good faith." In *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331 (7th Cir. 2000), the Seventh Circuit provided the following safe harbor language for inclusion in ERISA plans to insure that plan administrators receive deferential review by the courts: "Benefits under this plan will be paid only if the plan administrator

> decides in his discretion that the applicant is entitled to them." This court finds that the language contained in the Carle Clinic Association Pension Plan closely resembles the language set forth in *Herzberger*. Therefore, the decision of the Plan Administrator is entitled to deferential review.

Where the plan administrator's decision is entitled to deference, the court analyzes her decision under an arbitrary and capricious standard. *Brehmer v. Inland Steel Indus. Pension Plan*, 114 F.3d 656, 660 (7th Cir. 1997). Under this standard, the decision to deny benefits is "reviewed only to determine whether it was downright unreasonable." *Brehmer*, 114 F.3d at 659. Furthermore, this standard is "the least demanding from a judicial review of administrative action, and any questions of judgment are left to the administrator of the plan." *Trombetta v. Cragin Fed. Bank for Savings Employee Stock Ownership Plan*, 102 F.3d 1435, 1438 (7th Cir. 1997). "In other words, it is hard to overturn a decision of a plan administrator." *James v. General Motors Corp.*, 230 F.3d 315, 317 (7th Cir. 2000), *cert. denied*, 532 U.S. 973 (2001).

In her decisions denying "Plaintiffs' benefits, the Plan Administrator provided detailed reasons for the application of benefit limitations. In her letter to Helfrich, Swearingen indicated that paying the benefits requested would exceed the limits imposed by § 415 of the Code and incorporated into the Plan in §§ 1.01 and 4.07. Section 415 of the Code states that "[b]enefits with respect to a participant exceed the limitation of this subsection if, when expressed as an annual benefit . . . , such annual benefit is greater than the lesser of (A) $160,000 or (B) 100 percent of the participant's average compensation for his high 3

years." 26 U.S.C. § 415(b)(1). If these limits are exceeded, the Plan could lose its tax-qualified status pursuant to 26 U.S.C. § 401(a)(16) which states that "[a] trust shall not constitute a qualified trust . . . if the plan of which such trust is a part provides for benefits or contributions which exceed the limitations of section 415."

Plaintiffs did not dispute that the pension benefit requested by Helfrich would exceed these limitations. In fact, in a letter requesting review of Swearingen's decision, Helfrich did not question the applicability of these provisions. Rather, counsel for Helfrich indicated that "[w]hile it may have become impractical to provide Dr. Helfrich's full benefits through the existing defined benefit plan, that does not prevent Carle from making good on its promise; it merely requires payment through a separate pension plan." Likewise, Nelson recognized that ERISA "may or may not limit the amount of money that Carle Clinic Association is able to pay me on my retirement." Nelson went on to request benefits through a non-ERISA plan.

Plaintiffs now argue that Carle could have paid pension benefits in excess of the Code and Plan limitations because of Carle's 1995 lump sum payment to physicians to settle any potential claims for lost benefits. However, this settlement was not a benefit obtained through the Plan. Plaintiffs further argue that the pension benefits which they request would not exceed the limits imposed by the Code. Plaintiffs point to 26 U.S.C. §401(a)(17)(A) to support their argument. 26 U.S.C. §401(a)(17)(A) states:

> A trust shall not constitute a qualified trust under this section unless, under the plan of which such trust is a part, the annual compensation of each employee taken into account under the plan for any year does not exceed $200,000.

Plaintiffs points out that Henegar stated in a letter denying benefits to Nelson that compensation under a tax exempt plan was limited to $160,000. However, the limitation referenced by Henegar is a limitation on the amount of pension benefits imposed by § 415. § 401(a)(17)(A) applies only to the participant's wages that may be considered in determining a participant's benefit levels. Thus, Plaintiffs' argument is wholly devoid of merit.

Plaintiffs' also argue that the denial letters issued by Carle's Plan Administrators were deficient in meeting ERISA and Plan requirements. For instance, Plaintiffs argue that Swearingen's first denial of benefits to Helfrich on December 10, 1998, was only three sentences long and failed to reference plan provisions on which the decision was based. However, Swearingen supplemented this letter on January 29, 1999, with a four page decision upon request from Plaintiffs' counsel. Plaintiffs further point out that Swearingen's initial denial letter did not comport with Section 6.06(a) because the letter was not issued within 90 days of an application for claims. Rather, the letter was six days late. Finally, Plaintiffs take issue with the degree to which Nelson's denial letter lifted sections from the Plan.

Plaintiffs' qualms with the quality and timing of denial letters have no impact upon the correctness of the Plan Administrator's decision. Furthermore, "not all procedural effects . . . will upset a fiduciary's decision." *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 382 (7th Cir. 1994). "Substantial compliance with the regulations is sufficient." *Donato*, 19 F.3d at 382. While Swaringen's first denial letter to Helfrich may have been inadequate, it was supplemented with a full and complete explanation for the denial of Helfrich's benefits. This supplemental letter was

provided to Helfrich while he still had an opportunity for appeal and for a full and fair review, as evidenced by his request for review after receiving this more thorough letter. *See Schleibaum v. Kmart Corp.*, 153 F.3d 496, 499 (7th Cir. 1998), *cert denied*, 525 U.S. 1105 (1999). Furthermore, the fact that the initial denial letter was six days late is not a sufficient procedural defect to upset Swearingen's decision, and Plaintiffs cite no statutory or case law to support their argument that this delay is significant. Nevertheless, Plaintiffs make a convoluted and strained argument that these deficiencies require this Court to "remand to the administrators, not for further hearing or further consideration, but solely to complete the administrative record before returning this case to this Court to make its determination." This court has reviewed all documents submitted by the Plaintiffs, and this court is convinced that not only were the decisions of the Plan Administrator not "downright unreasonable," they were downright correct.

Section 1.03 of the Plan specifically states:

> In resolving any real or apparent conflict between provisions of the Plan and in resolving any other uncertainty as to the meaning or intention of any provision of this Plan, the interpretation that (1) causes the Plan to constitute a qualified plan under Section 401 of the Internal Revenue Code, with the contributions of the Employer to the trust as items deductible by the Employer from net income for federal income tax purposes, and (2) causes the Plan to comply with all applicable requirements of ERISA, the Internal Revenue Code and the regulations thereunder, shall prevail over any different or contrary interpretation.

The Plan incorporates the limits imposed by Sections 401(a)(17) and 415 of the Code in sections 1.01 and 4.07. Plaintiffs requested benefits of 50% of their average salaries from the five highest consecutive years within the last fifteen years of practice. These benefits would exceed the amount which could be awarded by the Plan and still remain a qualified plan under Section 401 of the Code. Therefore, this court concludes that the decisions of the Plan Administrator with regard to Plaintiffs' claims were neither arbitrary nor unreasonable.

C. Retroactive Reduction of Plaintiffs' Accrued Benefits

Plaintiffs next argue that Carle attempted to reduce their accrued pension benefits through amendments to the Plan in violation of ERISA § 204(g). Under this portion of ERISA, "[t]he accrued benefit of a participant under a plan may not be decreased by an amendment of the plan." 29 U.S.C. § 1054(g). "Thus the essential elements of a section 204(g) violation are: (1) a plan amendment, and (2) a reduction in accrued benefits." *Dooley v. American Airlines*, 797 F.2d 1447, 1451 (7th Cir. 1986), *cert. denied* 479 U.S. 1032 (1987). Plaintiffs point out that under the pre-1989 version of the Plan, those who retired at age 65 with 30 or more years of service received a lifetime monthly income of 50% of final average pay. Plaintiffs argue that this changed in 1989, when the Plan stated that the monthly amount of pension benefits would be 1.67% of the participant's average monthly compensation (subject to IRS limitations) multiplied by the participant's years of service (not to exceed 30 years), minus the participant's Social Security offset." Plaintiffs do not explain how the change in the actual formula would affect pension benefits.

In fact, these two formulas create the same amount of pension benefits.[1] Rather, Plaintiffs seem to be arguing that the inclusion of IRS limitations, specifically § 415 limitations, in the 1989 plan resulted in a reduction in accrued pension benefits.

Plaintiff's argument on this point is untenable. The § 415 limitations have been included in the Plan since 1976. Section 5.5 of the 1976 version of the Plan stated:

> Notwithstanding the foregoing, the otherwise permissible annual benefits for any Participant under this Plan may be further reduced to the extent necessary, as determined by the Committee, to prevent disqualification of the Plan under Section 415 of the Internal Revenue Code, which imposes the following additional limitations on the benefits payable to Participants . . .

These limitations were again incorporated in Section 5.5 of the 1989 version of the plan, which stated:

(b) Maximum Pension: Anything to the contrary notwithstanding, the provisions of Section 415 of the Code

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[1] Defendant correctly points out that the formula used in the 1989 version of the Plan clarifies the calculation incorporated in earlier versions of the Plan by setting forth the actual year by year accrual rate of 1.67% per year up to a maximum of 30 years, again subject to Section 415 limitations. Thus, under the 1989 version, a participant's benefits would be calculated as follows: 30 (years of service) x (1.67% of average compensation per year) = 50% of average compensation. An employee under either version of the Plan is entitled to 50% of his average compensation subject to Section 415 limits. Therefore, this court finds that the different equation used to determine the amount of pension benefits is a change of only form and not substance, and therefore does not constitute an amendment to the plan.

and the regulations thereunder, shall be incorporated herein by reference. In the event a reduction is necessary to avoid exceeding the combined plan limits under Section 415(e) of the Code, then such reduction shall first be made to this Plan.

The above limitations are intended to comply with the provisions of Section 415 of the Code as amended so that the maximum benefits provided by plans of the Employer shall be exactly equal to the maximum amounts allowed under Section 415 of the Code and regulations thereunder. If there is any discrepancy between the provisions of this Section 5.5(b) and the provisions of Section 415 of the code and regulations thereunder, such discrepancy shall be resolved in such a way as to give full effect to the provisions of Section 415 of the Code.

In 1994, the Plan was again amended, and again the Plan incorporated the § 415 limits. By doing so the Plan simply restated what was always true – pension benefits under the Plan were limited by § 415 of the Code. This court is "unwilling to contort the plain meaning of amendment so that it includes the valid exercise of a provision which was already firmly ensconced in the pension document." *Dooley*, 797 F.2d at 1451. Therefore, Plaintiffs cannot demonstrate that there was a plan amendment to satisfy the first prong of the analysis for a violation of ERISA § 204(g).[2]

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[2] Plaintiffs also argue that Carle should have submitted its amendments to the Secretary of Labor for approval. In support of this argument, Plaintiffs cite *Production and Maintenance Employees' Local 504 v. Roadmaster Corp.*, 954 F.2d 1397 (7th Cir. 1992). *Roadmaster* states that "the accrued benefit of a participant under a plan may not

(Continued on following page)

D. Estoppel

Plaintiffs also argue that Carle is barred from denying Plaintiffs' claims for benefits under the pre-1989 Plan based upon the doctrine of estoppel. "There are two types of ERISA plans: pension plans, which are funded and have strict vesting and accrual requirements; and welfare plans . . . which have no such requirements." *Black v. TIC Inv. Corp.*, 900 F.2d 112, 115 (7th Cir. 1990). The estoppel doctrine has been found to apply to claims for benefits under unfunded single-employer welfare benefit plans under ERISA. *Black*, 900 F.2d at 115. However, there is a "real resistance" to the use of the estoppel doctrine in ERISA cases. *Black*, 900 F.2d at 115. Furthermore, most circuits have declined to extend estoppel doctrines to funded plans. *Krawczyk v. Harnischfeger Corp.*, 41 F.3d 276, 290 (7th Cir. 1994). "The ordinary reason cited for this reluctance is the concern for the actuarial soundness of funded plans." *Krawczyk*, 41 F.3d at 280. The Seventh Circuit has repeatedly failed to extend the doctrine of estoppel to funded pension plans like the one in the instant case. *See Downs v. World Color Press*, 214 F.3d 802, 806 (7th Cir. 2000); *Krawczyk*, 41 F.3d at 280; *Shields v. Local 705*, 188 F.3d 895, 899-900 (7th Cir. 1999). While

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be decreased by an amendment to the plan absent submission of the amendment to and approval by the Secretary of Labor under § 302(c)(8) of ERISA, 29 U.S.C. § 1082(c)(8)." *Roadmaster*, 954 F.2d at 1403. However, this argument is meritless in the instant case because there was no reduction in accrued benefits.

Carle proceeds to argue that Plaintiffs could not accrue benefits in excess of § 415 limitations citing Notice 87-21, I.R.B. 1987-6. While this court finds that Carle's argument has merit, this court need not reach this issue based upon its finding that there was no amendment to the Plan resulting in a reduction of benefits.

the Seventh Circuit has not foreclosed the possibility of extending the estoppel doctrine in ERISA cases to funded plans, this court does not believe, based upon the facts of the instant case, that the doctrine should be applied here where Plaintiffs' claims are less than meritorious.

E. Summary Plan Production

Plaintiffs next argue that Carle violated ERISA by not producing a summary plan description of the 1989 Plan which allegedly reduced their accrued benefits. Plaintiffs contend that the § 415 limits were not imposed until the 1989 version of the Plan. 29 U.S.C. § 1024(b)(1)(B) provides that if there is a material modification in the terms of a plan, "a summary description of such modification or change shall be furnished not later than 210 days after the end of the plan year in which the change is adopted to each participant." As discussed above, the problem with Plaintiffs' argument is that § 415 limits were included in Carle's Plan since 1976. Because the placement of § 415 limits in the 1989 plan was not a material modification, there was no requirement for Carle to provide a plan summary description. Furthermore, failure to prepare a summary plan description in these circumstances can hardly be considered "direct evidence that Carle made knowing misrepresentations to the Plaintiffs and other employee-physicians" as Plaintiffs would have this court believe.[3]

[3] Plaintiffs also seem to make an argument that the summary plan descriptions provided by Carle conflict with the Plan itself because the summary plan descriptions do not indicate that § 415 limits apply to pension benefits. However, in the Seventh Circuit, a summary plan

(Continued on following page)

II. Motions to Strike

On September 28, 2001, Carle filed a Motion to Strike Plaintiffs' Statement of Facts and Supporting Exhibits (#67). Carle argues that the "vast majority of plaintiffs' 'facts' and supporting exhibits . . . are not supported by or contained within the administrative record and should be stricken." Plaintiffs respond by arguing that the administrative record proffered by Carle is incomplete. Because this court has found no merit to Plaintiffs' claims and is entering judgment in favor of Carle, this court denies Carle's Motion to Strike (#67) as MOOT. On October 3, 2001, Plaintiffs also filed a Motion to Strike Carle's Response to Plaintiffs' Material Facts From Plaintiffs' Motion for Summary Judgment (#68). Plaintiffs seek to strike Carle's response to Plaintiffs' statement of undisputed facts because Carle responded "through single sentences which listed multiple facts with which Defendant agreed, contested, or found immaterial." Carle did not go into great detail in their response to Plaintiffs' statement of undisputed facts in anticipation that Carle's Motion to Strike would be granted. While this court is unimpressed with Carle's less than complete compliance with Local Rule 7.1(D)(2), "[a] motion to strike may be granted or denied within the sound discretion of the district court." *Blaz v. Michael Reese Hosp. Found.*, 191 F.R.D. 570, 574 (N.D. Ill. 1999). In the exercise of this court's discretion, Plaintiffs' Motion to Strike (#68) is DENIED.

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description's "silence on an issue does not estop a plan from relying on the more detailed policy terms when no direct conflict exists." *Mers v Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1023 (7th Cir. 1998), *cert. denied*, 525 U.S. 947 (1998).

IT IS THEREFORE ORDERED:

(1) Plaintiffs' Motion for Summary Judgment (#59) is DENIED.

(2) Defendant's Motion for Summary Judgment (#63) is GRANTED. Judgment is entered in favor of Defendant and against Plaintiffs.

(3) Defendant's Motion to Strike (#67) is denied as MOOT.

(4) Plaintiffs' Motion to Strike (#68) is DENIED.

(5) This case is terminated.

(6) Defendant is allowed thirty (30) days to file a petition for fees pursuant to 29 U.S.C. § 1132.

ENTERED this 4th day of June, 2002.

/s/ Michael P. McCuskey
MICHAEL P. McCUSKEY
U.S. DISTRICT JUDGE

United States District Court
CENTRAL DISTRICT OF ILLINOIS

JUDGMENT IN A CIVIL CASE

(Filed Jun. 4, 2002)

RICHARD B. HELFRICH, M.D. and DANIEL B. NELSON, M.D.,

Plaintiffs,

vs. Case Number: **99-2232**

CARLE CLINIC ASSOCIATION,

Defendant.

[ ] **JURY VERDICT**. This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

[X] **DECISION BY THE COURT**. This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED that judgment is entered in favor of the defendant and against the plaintiffs. Case is terminated.

ENTER this 4th day of June, 2002.

/s/ John M. Waters
JOHN M. WATERS, CLERK

/s/ S. Johnson
BY: DEPUTY CLERK

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS
URBANA DIVISION

RICHARD B. HELFRICH, M.D., and DANIEL B. NELSON, M.D.,	)	
Plaintiffs,	)	**No. 99-2232**
v.	)	
CARLE CLINIC ASSOCIATION,	)	
Defendant.	)	

ORDER

(Filed Oct. 3, 2002)

Plaintiffs Richard Helfrich and Daniel Nelson initiated this action in September 1999, claiming that Carle Clinic Association, their former employer, unlawfully and retroactively reduced their accrued pension benefits in violation of the Employee Retirement Income Security Act (ERISA). On June 4, 2002, this court entered summary judgment in favor of Carle (#77).

Carle has now filed a Petition for Attorney's Fees and Expenses (#83), seeking $160,776.36.[1] Plaintiffs responded

[1] Page one of Carle's petition identifies the amount of costs and fees as $161,999.76, but page 13 of the petition requests $160,776.36. Carle specifically requests $43,931.92 for one of the law firms it hired, and $116,844.44 for another law firm. Given these numbers, the correct total Carle is seeking is $160,766.36.

(#90), arguing that Carle is not entitled to fees and that, if it is entitled to fees, its request is unreasonable. Carle then submitted a Reply Memorandum (#94).

Also before this court are Plaintiffs' Motion to Strike Defendant's Reply Memorandum (#95), in which Plaintiffs claim that the Local Rules do not permit Carle to file a reply, and Carle's Response to Plaintiffs' Motion to Strike (#96).

This court has carefully considered these filings, and for the reasons discussed below, Carle's request for attorneys' fees is GRANTED, and Plaintiffs' motion to strike is DENIED.

PETITION FOR FEES AND EXPENSES

1. Legal Entitlement to Fees

The ERISA statute provides that "[i]n any action under this subchapter . . . by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." 29 U.S.C. § 1132(g)(1). Courts evaluating this provision employ a "modest presumption" that the prevailing party is entitled to fees, *Hess v. Hartford Life & Accident Ins. Co.*, 274 F.3d 456, 464 (7th Cir. 2001), but this presumption may be rebutted, *Senese v. Chicago Area I.B. of T. Pension Fund*, 237 F.3d 819, 826 (7th Cir. 2001).

This circuit has identified two different frameworks for deciding whether attorneys' fees are appropriate. *Fritcher v. Health Care Serv. Corp.*, 301 F.3d 811, 819 (7th Cir. 2002). The first test looks at the following five factors: "(1) the degree of the offending party's culpability or bad faith; (2) the degree of the offending party's ability to

satisfy an award of attorney's fees; (3) the degree to which such an award would deter other persons acting under similar circumstances; (4) the amount of benefit conferred on all the plan members; and (5) the relative merits of the parties' positions." *Id.* (internal quotation marks and citation omitted). The second approach favors awarding fees to the prevailing party unless either "(1) the losing party's position was substantially justified or (2) special circumstances make a fee award unjust." *Central States, Southeast and Southwest Areas Pension Fund v. Hunt Truck Lines, Inc.*, 272 F.3d 1000, 1004 (7th Cir. 2001). Both formulations for applying the statute are merely alternative ways of asking the same question: "[W]as the losing party's position substantially justified and taken in good faith, or was that party simply out to harass its opponent?" *Id.* (quotation marks omitted).

Based on the protracted discovery proceedings and the untenable legal arguments, this court finds in its discretion that Plaintiffs' position was not substantially justified and that they failed to act in good faith in prosecuting this lawsuit. First, Plaintiffs legal arguments were frivolous. They continued to seek benefits not allowed by the plan without providing legal justification for doing so. This court found the plan administrators decision to be not only not "downright unreasonable," but also "downright correct." But Plaintiffs attempted to rely on inapplicable code sections and advanced arguments based on minute procedural errors. As noted in this Court's summary judgment order, some of Plaintiffs' contentions were "wholly devoid of merit," "convoluted and strained," and "less than meritorious."

Second, Plaintiffs filed repetitive motions and continually disputed this court's discovery orders. For example,

Plaintiffs filed two motions to compel Carle to comply with discovery requests. After determining that the plan administrator was entitled to deference, this court limited discovery to the administrative record and denied Plaintiffs' requests to expand discovery. Plaintiffs filed a motion to reconsider, but failed to raise proper grounds that would justify reconsideration, arguing instead that they had additional evidence to support their original claim that discovery should be expanded. The motion to reconsider was denied. Plaintiffs then filed a motion to compel the deposition of the plan administrator which essentially sought to revisit the discovery issues already addressed. Seeing no reason to explain for a third time why discovery was limited, this court denied the motion and entered a protective order prohibiting Plaintiffs from continuing to seek discovery outside of the administrative record. Additionally, Carle identifies in its petition notices and letters Plaintiffs tendered disputing again the discovery limitations.

This behavior, which is beyond zealous advocacy, was not substantially justified or in good faith. Accordingly, Carle is entitled to attorneys' fees.

2. Reasonableness of Fee Request

Plaintiffs argue that Carle's petition seeking over $160,000 is unreasonable on two grounds. First, Plaintiffs dispute the hourly rate Carle's attorneys charge. And second, Plaintiffs challenge a few specific billing items.

a. Hourly Rate

Carle employed two law firms at various times in this litigation, although never simultaneously. Attorney Mark

Casciari, a partner with Seyfarth, Shaw, Fairweather & Geraldson, bills at an hourly rate of $285. Attorney Michael A. Pollard, from Baker & McKenzie, is seeking reimbursement for $288 per hour.[2] Initially, the services of attorney William Dorsey, also of Baker & McKenzie, were charged to Carle at a rate of $171 per hour. Sometime during the pendency of this case, Dorsey's rate increased to $184.50 per hour. Christine S. Scott-Hayward, a paralegal/assistant at Baker & McKenzie, billed her work for Carle at a rate of $85.50.

In support of the reasonableness of the hourly rates, Carle notes first that the rates from the two different law firms are very similar, indicating that the rates thus approximate the reasonable market rate. Carle attached an affidavit from Pollard, detailing his extensive experience, including prior work on ERISA cases, and opining that the fees and expenses charged by both law firms were reasonable. Carle also directs this court to *Builders Association of Greater Chicago v. City of Chicago*, 2002 WL 1008455 (N.D. Ill. May 13, 2002), in which one of Casciari's partners was awarded attorneys' fees at rates between $290 and $340 per hour.

Plaintiffs argue that their attorneys' fees and costs were only $36,352.17 and that their attorneys bill at a considerably lower rate than that identified by Carle's counsel. Specifically, Plaintiffs refer to an affidavit from

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[2] Baker & McKenzie's fees were paid by Carle's insurer, Travelers Property & Casualty Company. Travelers negotiated a 10% discount on the amount owed to Baker & McKenzie. Accordingly, the hourly rates for Baker & McKenzie attorneys are 10% lower than that normally charged. The rates mentioned in this order reflect the 10% discount.

J. Steven Beckett, one of their lawyers, who billed his work at $200 per hour and who averred that his rate and the rates of the three other lawyers ($80 per hour for two of them and $125 per hour for the third) were reasonable for attorneys of their experience. Although Plaintiffs cite no cases to support their contention, they maintain that the rates charged by Carle's attorneys are unreasonable.

The Seventh Circuit provides that reasonable attorneys' fees may be awarded at the market rate – the rate "prevailing in the community for similar services by lawyers of reasonably comparable skill, experience, and reputation." *Harsch v. Eisenberg*, 956 F.2d 651, 663 (7th Cir. 1992) (citation omitted). Carle established the reasonableness of its rates with an affidavit from Pollard, comparison between its two law firms, and the recent case that involved fees over $290 per hour. Plaintiffs tried to negate this argument via their own counsel's affidavit, but Plaintiffs make no allegation that their attorneys share the same degree of experience in ERISA cases as Carle's lawyers do. Mere comparison of Plaintiffs' attorneys' hourly rates in Urbana, Illinois with that of attorneys from two large law firms from Chicago who have previously handled ERISA matters is insufficient to rebut the reasonableness of the rates charged by Carle's counsel.

b. Specific Billing Items

Plaintiffs object specifically to several charges in Carle's petition, totaling slightly more than $13,500. But Plaintiffs fail to explain the reasons for their challenges or cite any case law to support their argument. Instead Plaintiffs merely identify charges and note their disagreement. For example, Plaintiffs object to costs incurred

in creating a press release to respond to the lawsuit, ascertaining the extent of insurance coverage and the duty to disclose it, planning the transfer of the lawsuit to a different law firm, and creating and revising a budget for the case. These costs all appear to be incurred in the ordinary course of the litigation. Without more specific objections from Plaintiffs, this court concludes that these charges are reasonable for the nature of this lawsuit and the litigation strategy advanced by Carle.

Plaintiffs also object to attorneys' fees and copying costs associated with Carle's preparation of discovery materials, because, Plaintiffs argue, Carle insisted throughout the litigation that such discovery was improper. This objection cannot be sustained. These costs were incurred as a direct result of Plaintiffs' repeated discovery requests. Moreover, although Carle argued against Plaintiffs' motions to compel, it was perfectly reasonable for Carle to be prepared for this court to grant the motion.

MOTION TO STRIKE

Citing the local rules, Plaintiffs protest the reply filed by Carle in support of its petition for fees. It is within the sound discretion of this court, however, to strike documents filed by parties. *Cleveland v. Porca Co.*, 38 F.3d 289, 297 (7th Cir. 1994); *Mid-Am Builders, Inc. v. Federated Mut. Ins. Co.*, 194 F.Supp. 2d 822, 824-25 (C.D. Ill. 2002). The offending document was brief, did not raise any new arguments, and did not prejudice Plaintiffs. Accordingly, Plaintiffs' motion to strike is denied.

CONCLUSION

IT IS THEREFORE ORDERED:

(1) Carle's Petition for Attorney's Fees and Expenses (#83) is GRANTED. Carle is awarded $160,776.36 in costs and fees.

(2) Plaintiffs' Motion to strike (#95) is DENIED.

ENTERED this 2nd day of October, 2002.

/s/ Michael P. McCuskey

MICHAEL P. McCUSKEY

U.S. DISTRICT JUDGE

United States District Court
CENTRAL DISTRICT OF ILLINOIS

JUDGMENT FOR ATTORNEY FEES IN A CIVIL CASE

(Filed Oct. 3, 2002)

RICHARD B. HELFRICH, M.D. and DANIEL B. NELSON, M.D.,

Plaintiffs,

vs. Case Number: **99-2232**

CARLE CLINIC ASSOCIATION,

Defendant.

[ ] **JURY VERDICT**. This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

[X] **DECISION BY THE COURT**. This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED that judgment for attorney fees is entered in favor of the defendant and against the plaintiff in the amount of $160,776.36.

ENTER this 3rd day of October, 2002.

/s/ John M. Waters
JOHN M. WATERS, CLERK

/s/ Marilyn K. Talbott
BY: DEPUTY CLERK

United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604

July 1, 2003

Before

Hon. FRANK H. EASTERBROOK, Circuit Judge

Hon. MICHAEL S. KANNE, Circuit Judge

Hon. DIANE P. WOOD, Circuit Judge

RICHARD B. HELFRICH and DANIEL B. NELSON, *Plaintiffs-Appellants,* **Nos.** 02-2765 & 02-3871 **v.** CARLE CLINIC ASSOCIATION, P.C., *Defendant-Appellee.*	))))))))	Appeal from the United States District Court for the Central District of Illinois. No. 99-2232 Michael P. McCuskey, *Judge.*

Order

Plaintiffs-appellants filed a petition for rehearing and rehearing en banc on May 27, 2003. No judge in regular active service has requested a vote on the petition for rehearing en banc, and all of the judges on the panel have voted to deny rehearing. The petition for rehearing is therefore DENIED.

29 U.S.C.S. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 U.S.C.S. § 1109];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) [29 U.S.C.S. § 1025(c)];

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A) [29 U.S.C.S. § 1169(a)(2)(A)]);

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1) [29 U.S.C.S. § 1021(f)(1)], (A) to enjoin any act or practice which violates subsection (f) of section 101 [29 U.S.C.S. § 1021(f)], or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [subtitle] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and

has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle [29 U.S.C.S. §§ 1051 et seq., §§ 1081 et seq.] (relating to participation, vesting, and funding), only if –

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 515 [29 U.S.C.S. § 1145].

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 [29 U.S.C.S. §§ 1181 et seq.] against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 733(a)(1) [29 U.S.C.S. § 1191b(a)(1)]). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form.

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 606 or section 101(e)(1) [29 U.S.C.S. § 1166(a)(1) or (4) or § 1021(e)(1)] with

respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 101(b)(4) [29 U.S.C.S. § 1021(b)(4)]. For purposes of this paragraph, an annual report that has been rejected under section 104(a)(4) [29 U.S.C.S. § 1024(a)(4)] for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 101(d) [29 U.S.C.S. § 1021(d)] with respect to any participant or beneficiary or who fails to meet the requirements of section 101(e)(2) [29 U.S.C.S. § 1021(e)(2)] with respect to any person may in the court's discretion be liable to such participant or

beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 101(f)(1) [29 U.S.C.S. § 1021(f)(1)].

(5) Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 101(g) [29 U.S.C.S. § 1021(g)].

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 104(a)(6) [29 U.S.C.S. § 1024(a)(4)] the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary and the Secretary of Health and Human Services shall maintain an ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1144(c)(8) of the Social Security Act [42 U.S.C.S. § 1320b-14(c)(8)].

(d) Status of employee benefit plan as entity.

(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpena,

or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this title.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 101(f)(1) [29 U.S.C.S. § 1021(f)(1)]. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions.

(1) In any action under this title (other than an action described in paragraph 2) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section 515 [29 U.S.C.S. § 1145] in which a judgment in favor of the plan is awarded, the court shall award the plan –

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of –

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of the Internal Revenue Code of 1986 [26 U.S.C.S. § 6621].

(h) Service upon Secretary of Labor and Secretary of the Treasury. A copy of the complaint in any action under this title by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle [29 U.S.C.S. §§ 1101 et seq.]. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty. In the case of a transaction prohibited by section 406 [29 U.S.C.S. § 1106] by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of the Internal Revenue Code of 1986 [26 U.S.C.S. § 4975(f)(4)]) for each year or part thereof during which the prohibited transaction continues, except that, if the

transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of such Code [26 U.S.C.S. § 4975(f)(5)]) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of such Code [26 U.S.C.S. § 4975(e)(1)].

(j) Direction and control of litigation by Attorney General. In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28, United States Code), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor. Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this act, or to compel him to take action required under this title, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries.

(1) In the case of –

(A) any breach of fiduciary responsibility under (or other violation of) part 4 [29 U.S.C.S. §§ 1101 et seq.] by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1) –

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5).

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that –

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9)) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of the Internal Revenue Code of 1986 [26 U.S.C.S. § 4975].

(m) Penalty for improper distribution. In the case of a distribution to a pension plan participant or beneficiary in violation of section 206(e) [29 U.S.C.S. § 1056(e)] by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.